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No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

BENITO T. PEREZ,

Petitioner,

v.

AETNA LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. **DID THE SIXTH CIRCUIT COURT OF APPEALS ERR IN FINDING THAT AN "ARBITRARY AND CAPRICIOUS" STANDARD OF REVIEW", RATHER THAN THE "DE NOVO REVIEW" APPLIED SOLELY BECAUSE A DISABILITY INSURANCE PLAN WOULD PAY DISABILITY BENEFITS UPON SUBMISSION OF "SATISFACTORY" MEDICAL EVIDENCE?**

PARTIES TO THE PROCEEDING

Petitioners

Plaintiff-Appellant Benito Perez is the petitioner in the above entitled matter. Petitioner is an individual and has no corporate affiliation.

Respondent

Respondent is Aetna Life Insurance Company.

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4. Final three member panel applying "arbitrary and capricious" review for Defendant-Appellee Aetna

   Docket # 95-1111 (6th Cir; filed 2/10/2000) Appendix A

STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

Subject matter jurisdiction in this cause was vested in the United States District Court for the Western District of Michigan upon the filing of the complaint, naming Benito T. Perez, Jr. as Plaintiff and Aetna Life Insurance Company as Defendant by virtue of The Employee Retirement Income Security Act of 1974 (hereinafter ERISA) 29 USC 1001 et seq., (and specifically section 1132) which grants original jurisdiction to the District Court.

Appellate jurisdiction in this cause was vested in the Court of Appeals for the Sixth Circuit upon the filing of a notice of appeal by Plaintiff-appellant on January 24, 1995 from the December 7, 1994 final Order of Federal District Judge Richard Enslen, by virtue of 28 U.S.C. § 1291 which grants the Circuit Court of Appeals jurisdiction to review all final decisions of the District Courts.

The Sixth Circuit Court of Appeals rendered three orders in the above entitled matter, the third and ultimate final disposition, disposing of all claims of the parties. The three orders of the Court of Appeals are as follows:

A. Judgment of a three member panel of the Sixth Circuit favoring Plaintiff under the "de novo" standard, dated 9/23/96.

B. Judgment of the Sixth Circuit Court of Appeals sitting en banc, remanding to the three member panel for an "arbitrary and capricious" review, dated 2/3/97

C. Judgment of the original three member panel

of the Sixth Circuit under the "arbitrary and capricious" standard, dated 2/10/00.

This Petition for Writ of Certiorari is filed within 90 days of this final order of the Court of Appeals.

STATEMENT OF FACTS

The following facts are stated in the original decision of the Sixth Circuit:

> "While working for the Motor Wheel Corporation, a division of Goodyear Tire and Rubber, Perez suffered a severe injury to his heel and ankle when he jumped from a platform to escape an explosion of molten steel. Before his injury, Perez had worked for Motor Wheel for 16 years. At the time of his accident, Perez had only a limited education--a General Educational Development (GED) diploma obtained while he was in the military. Even so, Perez was earning $40,000 per year in 1971 as a production foreman. His accident occurred on November 24, 1984. Pursuant to the "Group Insurance Policy/Long Term Disability Benefits" (Plan) that Goodyear Tire & Rubber had negotiated with Aetna for the benefit of Goodyear employees, Perez was determined to be completely disabled and was granted disability benefits under the Plan beginning in December 1985. Perez is now 52 years old." Perez v. Aetna Life Insurance Company, 96 F.3d 813, 816; 65 USLW 2240; 20 Employee Benefits Cas. 1841; Pens.

Plan Guide P 23926B (6th Cir 1996) (Appendix D, pg 38a; emphasis added)

The benefits were terminated after the period of disability benefits referred to, based upon alleged employability following a period of training.

The procedural background makes this an excellent one for review by this Court. The Sixth Circuit Court of Appeals has rendered three decisions. The first determines that the District Court denial of benefits should be reversed based upon application of a de novo standard of review. That Court stated:

> ". . . we conclude, after applying a de novo standard of review to the meaning of the language of this Plan, that when a claimant produces evidence from a vocational expert that may support the conclusion that the claimant was not employable and such evidence is **unrefuted by any contrary vocational evidence**, the claimant has shown enough to resist a grant of summary judgment to the plan administrator, under § 1132(a)(1)(B)."(emphasis supplied)

The second decision was an en banc decision that remanded to the same three member panel, concluding that the appropriate review was under an "arbitrary and capricious" standard. (Exhibit four) The third, and final disposition, utilizing the standard imposed by the en banc decision, resulted in a dismissal of Plaintiff's claims. (Exhibit five)

The standard of review turns on the language of the

insurance policy, as analyzed by the first (ultimately reversed) three member panel decision:

> ". . . Aetna points to the following language in the Plan: "[s]ubsequent written proof of the continuance of such disability must be furnished to [Aetna] at such intervals as [Aetna] may reasonably require. . . . [Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . (2) that [the claimant] has furnished all required proofs for such benefits." (Footnote omitted) It is true that "[t]he Court in Firestone [v. Bruch] surely did not suggest that 'discretionary authority' hinges on incantation of the word 'discretion' or any other 'magic word.' Rather, the Supreme Court directed lower courts to focus on the breadth of the administrators' power--their 'authority to determine eligibility for benefits or to construe the terms of the plan.'" Block v. Pitney Bowes, Inc., 952 F.2d 1450, 1453 (D.C.Cir.1992) (quoting Bruch, 489 U.S. at 115, 109 S.Ct. at 956-57). However, the plain meaning of the provisions Aetna cites from the Plan does not give it discretionary authority. First, simply because Aetna has the ability to require written proof before continuing disability benefits does not mean that Aetna has the discretionary authority to decide whether that proof is sufficient within the meaning of the Plan. Second, simply because Aetna may require "satisfactory proof" does not give the insurance company discretionary authority, either. The quoted Plan provision

> does not specify to whom the proof should be satisfactory. Perez is probably correct in arguing that this language creates an objective standard--proof "satisfactory" to a reasonable person. But all we need decide at this point is that the language does not clearly give Aetna discretion, which is what the language of an ERISA plan must do under Bruch to trigger abuse of discretion review." Perez v Aetna Life Insurance Company, 96 F3rd 813, 826 (6th Cir. 1996)(Appendix D, 63a-64a)

The Court held:

> "We resolve a split of authority among the district courts in the Sixth Circuit by joining those circuits holding that a de novo standard of review applies to both factual determinations and plan interpretation determinations made by an ERISA plan administrator, unless the plan clearly gives a particular kind of discretion to the administrator. Applying this standard of review, we reverse the district court's grant of summary judgment to Aetna." supra at 816.

The en banc panel reversed the decision, directing it's attention to the same provision of the policy, in determining whether there was a grant of discretion to the insurer. The en banc panel held:

> "Although many of our prior cases finding a clear grant of discretion involved ERISA plans which explicitly provided that the evidence be satisfactory "to the insurer," "to the company"

or "to us," it does not automatically follow that in the absence of such language discretion has not been granted to the plan administrator. Both parties acknowledge that the Plan allows for Aetna to request and receive satisfactory evidence of total disability before an individual is entitled to receive continued benefits. We agree with Aetna that this "right to require as part of the proof of claim satisfactory evidence" means, semantically, that the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. It naturally follows that Aetna, the receiver of the evidence, would review that evidence to determine if it constitutes satisfactory proof of total disability. It is simply implausible to think that Aetna would merely hold the evidence as a safekeeper or depository for a third party unnamed in the contract to review in making benefits determinations. This is all the more true when one considers that an insurance contract, even one governed by ERISA, is after all simply a contract -- a mutual agreement between the two contracting parties." Perez v. Aetna Life Insurance Company, 150 F.3d 550, 557 (6th Cir 1998)(en banc) (Appendix exhibit four)

and later:

"It would not be rational to think that the proof would be required to be satisfactory to anyone other than [the insurance company]. Even if the phrase "to us" is interpreted as defining to whom the proof should be submitted, there is

no reason to believe that someone other than the party that received the proof would make a determination regarding its adequacy." Perez v Aetna Life Insurance Company, 150 F.3d 550, 558 (6th Cir 1998) (en banc) (Appendix B, pg 25a).

ARGUMENT

THE SIXTH CIRCUIT COURT OF APPEALS ERRED IN FINDING THAT AN "ARBITRARY AND CAPRICIOUS" STANDARD OF REVIEW", RATHER THAN THE "DE NOVO REVIEW" APPLIED SOLELY BECAUSE A DISABILITY INSURANCE PLAN WOULD PAY DISABILITY BENEFITS UPON SUBMISSION OF "SATISFACTORY" MEDICAL EVIDENCE

This Court addressed the issue of appropriate standards of review of an ERISA determination in Firestone Tire & Rubber Co. v Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). In Bruch, several former Firestone employees brought suit alleging that, under Firestone's employee benefit plan, it was required to pay them severance benefits. This Supreme Court held that:

> "ERISA abounds with the language and terminology of trust law. See, e. g., 29 U.S.C. 1002(7) ("participant"), 1002(8) ("beneficiary"), 1002(21)(A) ("fiduciary"), 1103(a) ("trustee"), 1104 ("fiduciary duties"). ERISA's legislative history confirms that the

> Act's fiduciary responsibility provisions, 29 U.S.C. 1101-1114, "codif[y] and mak[e] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts." H. R. Rep. No. 93-533, p. 11 (1973). Given this language and history, we have held that courts are to develop a "federal common law of rights and obligations under ERISA-regulated plans." Pilot Life Ins. Co. v. Dedeaux, supra, at 56. See also Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 24, n. 26 (1983) ("'[A] body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans'") (quoting 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)). In determining the appropriate standard of review for actions under 1132(a)(1)(B), we are guided by principles of trust law. Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570 (1985)." Firestone, supra at pg 489 U.S. 101, 110-111.

This Court noted that:

> "ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans," Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983), and "to protect contractually defined benefits," Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S., at 148. See generally 29 U.S.C. 1001 (setting forth congressional findings and

declarations of policy regarding ERISA). Adopting Firestone's reading of ERISA (an arbitrary and capricious standard) would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." Firestone, supra at 489 U.S. 101, 113-114.

This Court therefore held:

> As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with established principles of trust law, we hold that a denial of benefits challenged under 1132(a)(1)(B) **is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan**. Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, see 828 F.2d, at 143-146, we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries. Thus, for purposes of actions under 1132(a)(1)(B), the de novo standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary who

> is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion." Restatement (Second) of Trusts 187, Comment d (1959).

All subsequent cases understandably purport to follow the dictates of this ruling. However, the Circuit Court's of Appeal have entered into a varied and splintered approach to the determination of what language will be found to confer discretion upon a plan administrator. The degree to which the Courts have eliminated the stated right to a de novo review are illustrated by the rationale of the present case, as well as cases like Bollenbacher v Helena Chemical Co., 926 F.Supp 781, 787(N.D. Ind. 1996) and Caldwell v Life Ins Co. of North America., 959 F.Supp 1361 (D. Kan. 1997). These cases accept the proposition that simply requiring the submission of proof "by it's very nature" grants administrator discretion.

The case before this Court has become widely cited in many opinions throughout the nation. It rests squarely in the most deferential end of the spectrum, in the determination that nearly every plan must be considered to grant discretion to the insurer to determine whether it will pay it's own funds.

The "general rule" under this Court's opinion in Bruch, supra. Is that a de novo standard of review is appropriate. The ruling of the Sixth Circuit in this case results in exactly the opposite result. Absent an express withholding of discretion, nearly every policy reviewed would necessarily grant discretion to the insurer, eliminating any right to de novo review.

No policy authored by any insurer would state that

benefits will be paid upon the receipt "of evidence". Every policy includes some qualifier suggesting a quantum or quality of the evidence required. The rationale of the Court in the present case would find that any modifier, such as: "sufficient evidence", "good evidence", "reasonable evidence", or "adequate evidence" confers the requisite discretion. Under the rationale adopted, it would be "irrational" to suggest the evidence be "good" or "sufficient" to any entity but the insurer.

The better rationale is that of Court's that have reached the other conclusion. Kinstler v First Reliance Standard Life Insurance Company, 181 F.3d 243 (2d Cir. 1999)

> "As with the issue of the scope of de novo review, appellate judges are divided on the issue of what language suffices to convey to plan administrators the discretionary authority that warrants the more deferential arbitrary and capricious standard of review. This dispute is well illustrated by the Sixth Circuit's decision in Perez v. Aetna Life Insurance Co., 150 F. 3d 550 (6th Cir. 1998) (EN BANC), in which eight judges of the Court deemed the phrase "satisfactory evidence" sufficient to preclude de novo review, see id. at 555-58, and six judges found this phrase insufficient, see id. at 558-61 (Boggs, J., dissenting). The Ninth Circuit, also sitting in banc, has deemed insufficient the phrase "satisfactory written proof." Kearney, 175 f. 3d at 1087, 1999 WL 246485, at *3-*5. The seventh Circuit has deemed sufficient the phrase "proof . . . satisfactory to us, [i.e., the administrator,]"

Donato, 19 F.3d at 379 (emphasis added), but has also deemed sufficient the less rigorous phrase "such due proof, as shall be from time to time required," Patterson v. Caterpillar, Inc., 70 F.3d 503 (7th Cir. 1995) (internal quotation marks omitted)."

"In our Circuit, we have recognized that "'magic words such as "discretion" and "deference"' may not be 'absolutely necessary' to avoid a [de novo] standard of review." Jordan v. Retirement committee of Rensselaer Polytechnic Institute, 46 F.3d 1264, 1271 (2d Cir. 1995) (quoting Schein v. News America Publishing Inc., 1991 U.S. Dist. LEXIS 8504, No. 89 Civ. 0052, 1991 WL 117638, at *4 (S.D.N.Y. June 24, 1991)). At the same time, we have noted that the use of such words "is certainly helpful in deciding the issue." Id. When we have deemed the arbitrary and capricious standard applicable, the policy language reserving discretion has been clear. For example, in Ganton Technologies, Inc. v. National Industrial Group Pension Plan, 76 F.3d 462, 466 (2d Cir. 1996), the plan explicitly provided that the trustees had authority to "resolve all disputes and ambiguities relating to the interpretation of the Plan." In Zuckerbrod v. Phoenix Mutual Life Insurance Co., 78 F.3d 46, 48 (2d Cir. 1996), the policy used the phrase "in our judgment" to modify a determination of eligibility for benefits."

We agree with Judge Leisure that the language

of First Reliance's policy is insufficient to preclude de novo review. In the first place, it is not clear whether the key language requiring the claimant to "submit [1 satisfactory proof of Total Disability to us, "means only that the claimant must submit to First reliance proof that is satisfactory to First reliance. Since the plan administrator bears the burden of proving that the arbitrary and capricious standard of review applies, see Sharkey, 70 F.3d at 230, we think the needless ambiguity in the wording of the policy should be resolved against First Reliance, then the issue is like that in Perez and Kearney, and we think the dissenters in Perez and the majority in Kearney had the better of the argument. As the Perez dissenters pointed out, unless a policy makes it explicit that the proof must be satisfactory to the decision-maker, the better reading of "satisfactory proof" is that it establishes an objective standard, rather than a subjective one. See Perez, 150 F.3d at 559 (Boggs, J., dissenting)." Kinstler v First Reliance Standard Life Insurance Company, 181 F.3d 243, 251-252 (2nd Cir.1999) citing Kearney v. Standard Ins. Co., 175 F.3d 1084 (9th Cir. 1999), cert. denied, 120 Sct 398.

The Ninth Circuit has also held contrary to the Sixth Circuit's conclusions in the present case. Kearney v. Standard Ins. Co., supra the Court stated:

> Thus "satisfactory written proof that you have become disabled" means "proof that would be satisfactory to a reasonable person that you

have become disabled. Though the Sixth Circuit rejected this reading, Judge Boggs in dissent urged it persuasively. See Perez v. Aetna Life Ins. Co., 150 F.3d 550, 559 (6th Cir. 1998) (en banc) (Boggs, J., dissenting). This reading is consistent with well established common law principles for reading contracts, which are the principles that we are required, under Firestone, to apply.

In addition to the cited opinions of the Second and Ninth Circuits, well reasoned opinions of District Courts in the Seventh and Tenth Circuits also disagree with the Sixth Circuits conclusions. The Court in Lund v UNUM Life Insurance of America, 9 F.Supp 2d 1254, 1258 (Utah Dist1998) could not "reconcile the decision of Sixth Circuit in Perez with Firestone." The Court in Neurological Resources, P. C. v Anthem Insurance Companies, 61 F.Supp 2d 840, 848; 1999 U.S. Dist. Lexis 13051(Dist S. Ind, 1999) concluded:

> "Every plan that is administered requires submission of proof that will "satisfy" the administrator. No plan provides benefits when the administrator thinks that benefits should not be paid! Thus, saying that proof must be satisfactory"to the administrator" merely states the obvious point that the administrator is the decision-maker, at least in the first instance. Though we reiterate that no one word or phrase must always be used to confer discretionary authority, the administrator's burden to demonstrate insulation from de novo review requires either language stating that the award of benefits is within the discretion of the

> plan administrator or language that is clearly the functional equivalent of such wording. Since clear language can readily be drafted and included in policies, even in the context of collectively bargained benefit plans when the parties really intend to subject claim denials to judicial review under a deferential standard, courts should require clear language and decline to search in semantic swamps for arguable grants of discretion." Citing Kintsler, supra.

Contrary reasoning has been adopted with citation to this case in a number of other courts. The D.C. District cites the Sixth Circuit and then approves of its reasoning. It concludes that the mere ability to grant benefits necessarily requires an assessment of the proof. This assessment, that Court states: ". . . clearly partakes of discretion". Fitts v. Federal National Mortgage Association, 77 F.Supp 2d 9 (D.D.C. 1999). Bollenbacher v Helena Chemical Co., 926 F.Supp 781, 787(N.D. Ind. 1996) and Caldwell v Life Ins Co. of North America., 959 F.Supp 1361 (D.Kan. 1997) similarly follow this reasoning. The Seventh Circuit draws a line between the submission of satisfactory or due proof, and the added statement that the proof is submitted to the insurer (i.e. to "us"), or acceptable to the insurer. Compare Kintsler v First Reliance, with Patterson v. Caterpillar, Inc., 70 F.3d 503 (7th Cir. 1995)

This Court should grant review of the issue presented, and reverse the reasoning of the Sixth Circuit taken in this case. Rule 10 providing the Considerations Governing Review on Writ of Certiorari of this Court states the following grounds which are met here:

A. The Sixth Circuit's ruling is ". . . in conflict with the decision of another United States court of appeals on the same important matter". Rule 10(a).

B. The decision of the Sixth Circuit is in conflict with this Court's decision of Bruch v Firestone, supra, and is an "important question of federal law". Rule 10(c).

The decision affects the manner of review of millions of plans, policies, and benefit programs. The decision appealed has been cited in more than twenty five decisions in the short period of time from the en banc decision complained of to the time this Writ of Certiorari is sought. It has become an important precedent, albeit an incorrect one. Failure to grant review would eliminate the protections contemplated by this Court in Firestone, leaving ". . . a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted". Supra.

It is important for this Court to delineate the terms necessary to confer discretion upon a trustee to determine relevant issues. Plaintiff-Appellant urges this Court to grant leave, and ultimately hold that the terms of the "trust" should be strictly limited to avoid conferring an "arbitrary and capricious" standard of review, absent a specific grant of a specific power. Since the terms of a plan can be specifically written as the negotiating parties see fit, such an approach would insure that the employee's rights are protected.

There would be no loss of an ability of any party to render the plan reviewable under the more deferential standard. Only the ability to hide the true intent of the insurer

in ". . . semantic swamps for arguable grants of discretion" would be lost.

WHEREFORE, Plaintiff Appellant respectfully prays a Writ of Certiorari to the Sixth Circuit be granted.

Respectfully Submitted,

/s/_____

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APPENDIX A

NOT RECOMMENDED FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

[Filed February 10, 2000]

No. 95-1111

BENITO T. PEREZ, JR., *Plaintiff-Appellant*,

v.

AETNA LIFE INSURANCE COMPANY, *Defendant-Appellee*.

On Appeal from the United States District Court
for the Western District of Michigan

Before: **JONES, BOGGS,** and **COLE**, Circuit Judges.

OPINION

BOGGS, Circuit Judge. This ERISA case is before this panel on remand from an en banc decision of our court determining the proper standard for court review of the

decision of the Plan Administrator under the particular language of the Plan at issue in this case. The district court held that summary judgment upholding the Plan Administrator's denial of benefits to Mr. Perez was sustainable under either *de novo* review or "arbitrary and capricious" review. Our panel originally reversed, holding that *de novo* review was the correct standard and that under that standard, there were genuine issues of material fact precluding summary judgment. The en banc court determined, contrary to the panel, that the language of the Plan that Goodyear Tire and Rubber, Perez's employer, had purchased from Aetna Life gave the Plan Administrator discretion in making benefit determinations. 150 F.3d 550 (6th Cir. 1998) (en banc). When a Plan gives an Administrator such discretion, we may overturn those decisions only if the Administrator acted in an arbitrary and capricious manner. *Firestone Tire andRubber Co. v. Bruch,* 489 U.S. 101 (1989). We agree with the district court that the Administrator's decision in this case was not arbitrary and capricious, and we affirm.

I

The facts in this case have been well set out in two previous decisions by this court. We need note only that the crucial decision here, based on the language of the Plan, is whether Perez is "unable . . . to work at any reasonable occupation" because of his injury. Aetna concedes that Perez's injury, standing alone, rendered him unable to work at his previous occupation, which was as a production foreman. However, the Plan also defines reasonable occupation to include "any gainful activity for which the employee . . . may reasonably become . . . fitted by

education, training, or experience, and in which other people of similar background are actually employed as their principal means of support." The Plan Administrator determined that Perez's completion of an associate's degree in business management from Lansing Community College and additional computer skills training made Perez fitted to perform such gainful activity.

In our previous opinion, we set out the context of the dispute over Mr. Perez's employability as follows:

> The plain meaning of the requirement that Perez be able to engage in gainful activity "in which other people of similar background are actually employed as their principal means of support" is that Perez: (1) be capable of working at a job where individuals with similar education, training, or experience were actually working; and (2) that such jobs provide the principal means of support for such individuals. This is because the referent of the term "background" is "education, training, or experience." Thus, Perez's argument that Aetna would have to show that someone with an associate's degree from Lansing Community College who had the same injuries Perez had to his or her heel and ankle was working as, for example, a customer service representative at a bank must be rejected. "Background" does not refer to a similar physical or mental impairment, but, in context, refers to similar education, training, or experience. Perez's suggestion at various

points throughout his briefs that "reasonable occupation" requires him to be able to find a job comparable perhaps in salary and status to his former employment at Motor Wheel is also without support in the Plan language.

The district court's assessment of the Plan's "reasonable occupation" language has its own difficulties: "However, nothing in the disability policy requires that plaintiff be competitively employable or be actually able to find a job." While it is true that the language in the Plan does not mandate that Perez actually find a job, it does mandate, contrary to what the district court stated, that Perez *be able* to find a job. If Perez were not able to find a job, then he would not be "fitted" to engage in some "gainful activity." The district court was correct in noting, however, that there is no requirement in the Plan's language that Perez be "competitively employable." Thus, that part of the letter from vocational expert O'Malley opining that Perez was not "competitively employable" without additional computer training does not bear on Perez's claim one way or the other. One obvious interpretation of O'Malley's statement, taken in isolation, is that Perez may have been employable without the computer course, but that he would have had a hard time finding employment in those circumstances. At another point, however, O'Malley opined more definitively that "for the reasons

> described above, Mr. Perez was not yet employable." In context, O'Malley may be doing nothing more than reiterating her earlier opinion that Perez is not "competitively employable." The unqualified statement, on the other hand, may mean that O'Malley thinks that "competitively employable" was just another way of saying "employable." Indeed, Perez makes an argument that the two terms are identical. We are forced to conclude that O'Malley's intended meaning is ambiguous.
>
> Aetna places heavy reliance on various medical opinions that basically conclude Perez is capable of performing some kinds of sedentary work. The Plan, however, requires that Perez be able to engage in gainful activity to which he is suited by means of his education, training, or experience. These are matters not within the province of the medical experts Aetna relies upon. Perez requests that we hold that the language of the Plan requires Aetna to solicit vocational expert testimony determining which "reasonable occupations" are actually available to a claimant before denying benefits.

Panel opinion at slip op. 26-28.

II

Thus, this panel had previously concluded that there was ambiguity, in certain items of the Plan language, as well as in relevant opinions as to Perez's employability. However,

the Administrator is entitled to deference in Plan interpretation, as well as interpretation of the relevant facts, so long as those determinations are not arbitrary and capricious. While we determined that there were genuine issues of material fact under a *de novo* review, we must agree with the district court that the Administrator was not arbitrary and capricious in determinating that the Plan only requires that a person, in the words of Aetna's denial, be "able to pursue some reasonable occupation," even though his actual marketability may be problematic. Although Perez's rehabilitation counselor opined that he would be "at a disadvantage" in "today's highly competitive job market," the Administrator is not required to find him disabled on that basis.

Operating under the proper standard, we find no fault with the heart of the district court's opinion:

> Plaintiff appears to argue that he had to be able to "find employment," or that he had to be "competitively" employable, as mentioned in a draft letter that plaintiff cites that was apparently written by Ms. O'Malley. These statements concern the fact that plaintiff would likely benefit from computer training, making him even more employable. However, nothing in the disability policy requires that plaintiff be competitively employable or be actually able to find a job. Therefore, even if computer training was necessary for plaintiff to obtain a job in the actual competitive environment, this would not constitute a "disability" triggering benefits under the

policy. As noted above, he need only be shown to be able to perform jobs that other people with similar education, training, and experience are performing.

The judgment of the district court is therefore AFFIRMED.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[Filed July 1, 1998]

No. 95-1111

BENITO T. PEREZ, JR.,
Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant-Appellee.

Before: MARTIN, Chief Judge; MERRITT, KENNEDY, JONES, NELSON, RYAN, BOGGS, NORRIS, SUHRHEINRICH, SILER, BATCHELDER, DAUGHTREY, MOORE, and COLE, Circuit Judges.

OPINION

SUHRHEINRICH, Circuit Judge.

The matter before the en banc court today stems from a panel decision by this Court reversing Aetna Life Insurance Company's ("Aetna") decision to terminate disability benefits

to Bonito Perez, Jr., ("Perez") under a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461. The panel held that the language "[Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for [receipt of] benefits" did not vest discretion in Aetna to make benefits determinations.[1] *Perez v. Aetna Life Ins. Co.*, 96 F.3d 813, 825-26 (6th Cir. 1996), *vacated*, 106 F.3d 146 (6th Cir 1997). Given that conclusion, the panel reached the related issue of whether the de novo standard of review announced in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), applies to factual determinations made by a plan administrator.[2]

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[1] In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), the United States Supreme Court held that "a denial of benefits challenged under [ERISA] § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority. . . ." *Id.* at 115, 109 S.Ct. 948.

[2] Since *Firestone* was decided, the federal courts of appeals have disagreed on whether the de novo standard of review applies to both plan interpretation and fact determinations made by a plan administrator or is limited only to plan interpretation. *Compare Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1559 (5th Cir. 1991) (practical considerations dictate that the de novo standard applies only to plan interpretation and a deferential standard applies to fact determinations), with *Luby v. Teamsters Health, Welfare, and Pension Trust*, 944 F.2d 1176, 1183-84 (3d Cir. 1991) (de novo review applies to fact determinations unless plan administrator granted discretion to determine eligibility for benefits). In this case, both parties agree that Aetna's decision to

The panel's decision in *Perez* conflicted with a prior panel's decision in *Yeager v. Reliance Standard Life Ins. Co.*, *88* F.3d 376 (6th Cir.1996). The *Yeager* panel held that similar plan language vested discretion in the plan administrator to make benefits determinations. *Id.* at 380.

To resolve this conflict, we voted to rehear the case en banc to address too specific issues: 1) whether the Plan language grants Aetna discretion; and 2) whether the de novo standard of review announced in *Firestone* applies to both fact determinations and plan interpretation, or only to plan interpretation. *Perez v. Aetna Life Ins. Co.*, 106 F.3d 146 (6th Cir. 1997). For the following reasons, we conclude that the Plan language grants Aetna discretionary authority to make benefits determinations. We therefore do not reach the issue of whether the de novo standard announced in *Firestone* applies to factual determinations made by a plan administrator.

I. FACTS

For sixteen years, Perez worked for the Motor Wheel Corporation, a division of Goodyear Tire and Rubber Company located in Lansing, Michigan. In 1984, Perez suffered a work-related injury when he jumped from a platform to avoid an explosion of molten steel. The accident fractured his left heel and foot. Doctors inserted metal screws and pins into Perez's foot and surgically fused his ankle joint. As a result, effective December 1, 1985, Aetna considered

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terminate benefits encompassed fact determinations as opposed to plan interpretation.

Perez "totally disabled" within the meaning of the Plan and he began receiving disability benefits.[3]

In 1987, Perez enrolled in Lansing Community College to pursue an associate's degree in business management.[4] On August 12, 1988, Perez's rehabilitation counselor wrote to Aetna estimating that "Mr. Perez will complete his educational program either at the completion of Spring or Summer term, 1989. Following completion of this program, job placement assistance will be provided until Mr. Perez has obtained employment." J.A. at 245. However, Perez did not complete his degree until March of 1991, approximately two years behind schedule. From 1985 to 1991, Aetna continued to provide disability benefits to Perez.

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[3] The Plan defines "total disability" and "totally disabled" as "during the twelve month qualifying period and thereafter during any one period of disability, that the employee is unable, solely because of disease, accidental bodily injury or a pregnancy-related condition to work at any reasonable occupation." J.A. at 19. "Reasonable occupation" is defined as "any gainful activity for which the employee is, or may reasonably become, fitted by education, training, or experience, and in which other people of similar back ground are actually employed as their principal means of support." *Id.*

[4] Michigan law requires its residents who suffer work-related injuries and receive disability benefits to obtain retraining where possible. Mich.Comp.Laws Ann. § 413.319(1) (West Supp.1998). At the time of his accident, Perez had only a General Education Development (GED) diploma obtained while he was in the military.

On April 8, 1991, Aetna informed Perez by letter that his benefits would extend "through June 30, 1991, or until such time as [he] secured employment, but not beyond June 30, 1991." J.A. at 330. In accordance with this letter, Perez has received no disability benefits from Aetna since June 30, 1991.

On June 21, 1991, Perez enrolled in a computer training course scheduled to last 12 weeks. In subsequent letters, Perez sought review of Aetna's decision to terminate his benefits and requested an extension of his coverage until he could complete additional training to make him employable. J.A. at 291-92, 310. Perez's rehabilitation counselor, in an unsigned March 18, 1992, letter addressed to Acme, described Perez's situation as follows:

> Initial job placement efforts revealed that Mr. Perez needed computer skills to compete for entry-level jobs in the business field. His Business Management program at Lansing Community College did not include computer skills training, and with his prior work history comprised primarily of factory work, Mr. Perez was not suitably prepared for an entry-level business position.
>
> Since mid-June, 1991, Mr. Perez has been involved with an individualized, hands-on computer skills training program with Smith & Bell Computer Training institute, Inc. in Lansing, Michigan. . . .

> . . . Th[is] training program has had to be further extended because of major medical problems experienced by Mr. Perez from December 1991 through March 1, 1992. . . . In summary it is my professional opinion that Mr. Perez was not yet competitively employable with the completion of his Associate Degree in Business Management. . . . [I]n today's highly competitive job market, Mr. Perez is at a disadvantage without additional short-term [computer] training. It is my understanding that Mr. Perez' LTD [Long-Term Disability] Benefits were discontinued because of the assumption that he was employable with the Associate Degree in Business Management. However, for the reasons described above, Mr. Perez was not yet employable. . . .

J.A. at 441-42.

In response to Perez's repeated requests for an extension of his benefits, Aetna wrote to Perez on February 26, 1992:

> You . . . wrote us on September 9, 1991, and more recently on February 12, 1992. You are requesting an extension of Long-Term Disability benefit coverage, in order that you may secure additional training and expertise involving the use of personal computers. . . . We don't dispute that this additional training would be helpful but we feel that it, is not

> essential in determining whether or not you presently have the training to pursue some reasonable occupation that others with the same training that you have are engaged in gainful work. We feel that you have acquired sufficient education and skills by virtue of your attaining your Associate of Arts Degree in Business Management and are now able to pursue some reasonable occupation. Therefore, we must refuse your request for extension of Long-Term Disability Benefits beyond June 30, 1991.

J.A. at 125-26.

This letter became Aetna's final determination that Perez was able to engage in a reasonable occupation, and therefore no longer totally disabled under the Plan.

In addition to his benefits from Aetna, Perez collected workers' disability compensation from the State of Michigan until December 5, 1992. On that date, Perez was offered employment as a lab technician with the Laboratory of Clinical Medicine of Michigan State University. He began working there on December 7, 1992, but quit after only one full week on the job. After quitting, Perez applied for reinstatement of his worker's compensation benefits. In an administrative hearing, a Michigan worker's compensation magistrate denied Perez's request for reinstatement of his benefits, concluding that Perez could and did perform work as a lab technician.

Perez sued Aetna under ERISA "to recover benefits due to him under the terms of his plan. . . ." *Id.* § 1132(a)(1)(B). The district court granted summary judgment to Aetna and denied Perez's cross-motion for summary judgment. Perez then moved to alter or amend the judgment under Fed.R.Civ. P. 59(e), which the district court denied. Perez appealed the district court's grant of summary judgment for Aetna and also its denial of his motion to amend the judgment. The original panel of this court reversed the district court's decision and we granted this en banc review.

II. STANDARD OF REVIEW

We generally review a denial of a motion to alter or amend the judgment under Rule 59(e) for abuse of discretion. *Huff v. Metropolitan Life Ins. Co.*, 675 F.2d 119, 122 (6th Cir. 1982). However, when the Rule 59(e) motion seeks review of a grant of summary judgment, as in the case at bar, we apply a de novo standard of review. *Columbia Gas Transmission Corp. v. Limited Corp.*, 951 F.2d 110, 112 (6th Cir. 1991) (citing *Huff* 675 F.2d at 122-23 n. 5).

Under Rule 56(e) of the Federal Rules of Civil Procedure, summary judgment is appropriate when there is no genuine issue of material fact for trial, and the moving party is entitled to judgment as a matter of law. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986) (citing Fed. R.Civ. P. 56(e)). In ruling on a motion for summary judgment, all reasonable inferences must be drawn in favor of Perez, the non-moving party. *Timmer v. Michigan Dep't of Commerce*, 104 F.3d 833, 842 (6th Cir. 1997) (citation omitted).

III. COLLATERAL ESTOPPEL

Before turning to the principal issue on appeal, we must dispose of Aetna's argument that the refusal by a Michigan worker's compensation magistrate to reinstate Perez's worker's compensation benefits collaterally estops Perez from challenging Aetna's termination of his benefits. Specifically, Aetna contends that the magistrate's conclusion that Perez could and did perform the lab technician job precludes him from asserting that no reasonable occupation exists for which he is qualified.

Although Aetna raised collateral estoppel in its motion for summary judgment, the district court granted summary judgment without deciding this issue. Typically, we will not address issues unless ruled upon by the trial court below. *Maldonado v. National Acme Co.*, 73 F.3d 642, 648 (6th Cir. 1996) (declining to rule upon collateral estoppel issue not addressed by the district court). Only when "the proper resolution is beyond doubt" or "injustice might otherwise result" will we consider a collateral estoppel issue not addressed below. *Id.* (quoting *Meade v. Pension Appeals and Review Committee*, 966 F.2d 190, 194 (6th Cir. 1992)).

We decline to invoke this extremely narrow exception in this case because it is not "beyond doubt" that Aetna's collateral estoppel argument would prevail. Under Michigan law, Aetna "must also have been a party, or a privy to a party" in the state court proceeding to invoke the doctrine of

collateral estoppel against Perez[5]. *Lichon v. American Universal Ins. Co.*, 435 Mich. 408, 459 N.W.2d 288, 297-98 1990. See also, *Nummer v. Treasury Dep't*, 448 Mich.534, 533 N.W.2d 250, 253 (1995) (including mutuality in list of requirements necessary to give preclusive effect to administrative determinations under Michigan law). Since Aetna was not a party to the Michigan worker's compensation proceedings, we cannot conclude that "injustice might otherwise result" from our refusal to affirm the district court's grant of summary judgment on collateral estoppel grounds.

IV. DISCRETIONARY AUTHORITY UNDER THE PLAN

We now reach the primary issue in this case: whether the Plan vests discretionary authority in Aetna, the plan administrator. If it does, we must apply the arbitrary and capricious standard of review to Aetna's decision to terminate benefits. *Wendy's Int'l. Inc. v. Karsko*, 94 F.3d 1010, 1012 (6th Cir. 1996) (citing *Firestone*, 489 U.S. at 111 109 S.Ct. 948)

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[5] Federal law requires us to consult the relevant state law to determine the potential preclusive effect of a prior state court judgment. 28 U.S.C.A § 1738 (West 1994). *See also Marrese v. American Academy of Orthopaedic Surgeons*, 470 U.S. 373, 380, 105 S.Ct. 1327, 84 L.Ed.2d 274 (1985) (noting that § 1738 "directs a federal court to refer to the preclusion law of the State in which the judgment was rendered"). Because Aetna's collateral estoppel argument rests upon the decision of a Michigan agency, we consult the state law of Michigan.

We begin our analysis with the proposition that "'[t]he Court in *Firestone* . . . did not suggest that "discretionary authority" hinges on incantation of the word "discretion" or any other "magic word."'" *Johnson v. Eaton Corp.*, 970 F.2d 1569, 1572 n. 2 (6th Cir. 1992) (quoting *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1453 (D.C.Cir. 1992)). "Rather, the Supreme Court directed lower courts to focus on the breadth of the administrator's power – their 'authority to determine eligibility for benefits or to construe the terms of the plan.'" *Block,* 952 F.2d at 1453 (quoting *Firestone,* 489 U.S. at 115, 109 S.Ct. 948). While "magic words" are unnecessary to vest discretion in the plan administrator and trigger the arbitrary and capricious standard of review, this circuit has consistently required that a plan contain "a *clear* grant of discretion [to the administrator] to determine benefits or interpret the plan." *Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368, 1373 (6th Cir. 1994). *See. e.g. Tiemeyer v. Community Mut. Ins. Co.*, 8 F.3d 1094, 1099 (6th Cir. 1993) (absence of a clear grant of discretion dictates a de novo standard of review); *Anderson v. Great West Life Assurance Co.*, 942 F.2d 392, 395 (6th Cir.1991) (same); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 550 (6th Cir. 1998) (same).

Arguing that the Plan contains the requisite clear grant of discretion to the plan administrator, Aetna points to the following Plan language:

> Written proof of total disability must be furnished to [Aetna] within ninety days after the expiration of the [First twelve months of disability]. Subsequent written proof of the continuance of such disability must be

> furnished to [Aetna] at such intervals as [Aetna] may reasonably require. . . .
>
> *[Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for such benefits . . .*

J.A. at 32 (emphasis added).

Perez counters that this language does not constitute a clear grant of discretion because it does not specify *to whom* the written proof of disability must be satisfactory. Both parties agree, however, that the locus of any discretion lies in the final sentence of the above quoted paragraph.

Numerous federal courts, including our own, have held that language similar to that contained in the Plan clearly grants discretion to the plan administrator. *Yeager*, 88 F.3d at 380-81 (claimant must submit "satisfactory proof of Total Disability to us"); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir. 1991) (disability determined "on the basis of medical evidence satisfactory to the Insurance Company"); *Snow v. Standard. Ins. Co.*, 87 F.3d 327, 330 (9th Cir. 1996) (company must be presented with what it considers to be satisfactory proof of the claimed loss); *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 505 (7th Cir. 1995) ("benefits will be payable only upon receipt by the Insurance Carrier or Company of . . . due proof . . . of such disability"); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) ("[a]ll proof must be satisfactory to us"); *Bali v. Blue Cross & Blue Shield Ass'n*, 873 F.2d 1043, 1047 (7th Cir. 1989) (disability "determined on the basis of

medical evidence satisfactory to the Committee"); *Caldwell v. Life Ins. Co. of North America,* 959 F.Supp. 1361, 1365 (D.Kan. 1997) (benefits paid upon receipt of "due proof" that employee is disabled); *Miller v. Auto-Alliance Int'l. Inc.*, 953 F.Supp. 172, 175 (E.D.Mich.1997) (benefits paid "when [insurer] receive[s] notice and satisfactory proof of loss") (citing *Miller* and *Yeager, supra*); *Bollenbacher v. Helena Chem., Co.*, 926 F.Supp. 781, 786 (N.D.Ind. 1996) (benefits paid "[w]hen the Company receives proof that the individual is disabled"); *Scarinci v. Ciccia,* 880 F.Supp. 359, 361 (E.D.Pa. 1995) (to qualify for benefits, employee must "furnish certification satisfactory to the Company of disability"). Perez distinguishes these cases on the ground that the language at issue in each case required the proof or evidence of disability to be satisfactory *to the insurer or plan administrator.* Since the Aetna Plan does not contain such language, the question becomes whether in the absence of such language -- in grammatical terms and indirect object -- the Plan constitutes a clear grant of discretion.[6]

Because the Plan is governed by ERISA, we apply federal common law rules of contract interpretation in making our determination. *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir.1996). In developing federal common law rules of contract interpretation, we take direction from both state law and general contract law principles. *Regents of the Univ. of Michigan v. Agency Rent-A-Car,* 122 F.3d 336,

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[6] Neither party disputes that the Plan empowers Aetna to request receipt of "satisfactory evidence" of disability. The question is not who receives the evidence but rather who determines whether the submitted evidence is "satisfactory."

339 (6th Cir. 1997). The general principles of contract law dictate that we interpret the Plan's provisions according to their plain meaning, in an ordinary and popular sense. *Id.* Other circuits agree with this plain meaning approach to interpretation of ERISA contract provisions. *Pitcher,* 93 F.3d at 411 (interpreting ERISA-regulated policy" '[i]n an ordinary and popular sense as would a person of average intelligence and experience. . . .'") (quoting *Meredith v. Allsteel Inc.,* 11 F.3d 1354, 1358 (7th Cir. 1993)); *Bartlett v. Martin Marietta Operation Support Inc. Life Ins. Plan* 38 F.3d 514, 517 (10th Cir. 1994) (applying plain meaning analysis); *Hughes v. Boston Mut. Life Ins. Co.,* 26 F.3d 264, 268 (1st Cir. 1994) (giving language in an ERISA-regulated insurance policy its "natural meaning"). In applying this plain meaning analysis, we "must give effect to the unambiguous terms of an ERISA plan." *Lake v. Metropolitan Life Ins. Co.,* 73 F.3d 1372, 1379 (6th Cir. 1996).

Although many of our prior cases finding a clear grant of discretion involved ERISA plans which explicitly provided that the evidence be satisfactory "to the insurer," "to the company" or "to us," it does not automatically follow that in the absence of such language discretion has not been granted to the plan administrator. Both parties acknowledge that the Plan allows for Aetna to request and receive satisfactory evidence of total disability before an individual is entitled to receive continued benefits. We agree with Aetna that this "right to require as part of the proof of claim satisfactory evidence" means, semantically, that the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. It naturally follows that Aetna, the receiver of the evidence, would review that evidence to determine if it constitutes satisfactory proof of total disability.

It is simply implausible to think that Aetna would merely hold the evidence as a safekeeper or depository for a third party unnamed in the contract to review in making benefits determinations. This is all the more true when one considers that an insurance contract, even one governed by ERISA, is after all simply a contract - a mutual agreement between the two contracting parties.

In short, reading the contractual language in an ordinary and popular sense as we must, the only reasonable interpretation of the Plan is that Aetna requests the evidence, reviews it, and then makes a benefits determination.[7] To reach any other conclusion would violate the basic principle of contract law that courts are not permitted to rewrite contracts by adding additional terms. *See Phico Ins. Co. v. Providers Ins. Co.*, 888 F.2d 663, 667 (10th Cir.1989)

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[7] The rule of *contra proferentum* provides that ambiguous contract provisions in ERISA-governed insurance contracts should be construed against the drafting party. *Schachner v. Blue Cross & Blue Shield,* 77 F.3d 889, 895 n. 6 (6th Cir. 1996). Citing this common law canon of contract interpretation, Perez argues that the Plan should be strictly construed against Aetna. The rule *of contra proferentum,* however, only applies to *ambiguous* contract provisions. *Id.* (refusing to consider rule where provision is unambiguous). Ambiguity requires two reasonable interpretations. *Id.* Furthermore, mere disagreement between the parties does not create ambiguity in the legal sense. *D.E.W., Inc. v. Local 93, Laborers' Int'l Union,* 957 F.2d 196, 199 (5th Cir. 1992) (applying federal law of contract interpretation). Because the only reasonable interpretation of the Plan concludes that it vests discretion in Aetna to make benefits determinations, Perez's *contra proferentum* argument lacks merit.

(recognizing "the universal rule that courts will not make contracts under the guise of judicial interpretation"). *See also American Flint Glass Workers Union, AFL-CIO v. Beaumont Glass Co.*, 62 F.3d 574, 581 (3d Cir. 1995) (noting that the four corners of the contract provide the starting point for contract interpretation). We therefore conclude, that the plan clearly grants discretion to Aetna because, under the only reasonable interpretation of the language, Aetna retains the authority to determine whether the submitted proof of disability is satisfactory.

Although the case before us today presents a slight variation, our conclusion that the Plan vests discretion in Aetna follows naturally from our prior Sixth Circuit decisions addressing similar plan language cases.[8] In *Miller*, we applied *Firestone* and held that the language "on the basis of medical evidence satisfactory to the Insurance Company" clearly vested discretion in the plan administrator. *Id.* at 983-84. In *Yeager*, we extended *Miller* and held that the language

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[8] Although we agree with Aetna on the merits, we note that Aetna could easily have obviated this entire controversy over the appropriate standard of review by simply inserting the language "to us" following "satisfactory evidence." It has long been the law in this circuit that plans containing such language clearly grant discretion to the plan administrator. *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 983-84 (6th Cir. 1991). Aetna, however, failed to reflect our well-established precedent in the Plan. We hope that in the future insurance companies will take better notice of Sixth Circuit precedent and draft their contracts accordingly. Otherwise, valuable private and judicial resources will continue to be consumed deciding issues that could have been definitively resolved years earlier through sound contract formation.

"satisfactory proof of Total Disability to us" also clearly vested discretion in the plan administrator. *Yeager*, 88 F.3d at 380. The district court in *Yeager* had found this contractual language ambiguous because it was unclear whether the phrase "to us" modified "submits" or "satisfactory proof of Total Disability." *Id.* at 381. The district court held that this absence of explicit contractual language meant that the plan administrator had not clearly been granted discretion under the plan. *Id.* In reversing the district court's decision, we stated:

> We can find no meaningful distinction between the language in the present Plan and that in *Miller*. The critical requirement in *Miller* is that the evidence of disability be satisfactory. A determination that evidence is satisfactory is a subjective judgment that requires a plan administrator to exercise his discretion. Like the *Miller* plan, the Plan at issue in this case requires "satisfactory proof of total disability." It would not be rational to think that the proof would be required to be satisfactory to anyone other than [the insurance company]. Even if the phrase "to us" is interpreted as defining to whom the proof should be submitted, there is no reason to believe that someone other than the party that received the proof would make a determination regarding its adequacy.

Id. at 381.

Thus, in *Yeager* we concluded that a plan's failure to designate to whom the submitted proof must be satisfactory did not mean that discretion to determine eligibility benefits had not been clearly granted to the plan administrator. *Id.* Although the panel in *Yeager* noted that "the Plan language could have been clearer," it held that "[t]he mere fact that language could have been clearer does not necessarily mean that it is not clear enough." *Id.*

The panel in *Yeager* reached the only reasonable interpretation of the language at issue in that case when the panel concluded that "it would not be rational to think that the proof would be required to be satisfactory to anyone other than [the insurance company]." This case presents an issue identical to the one presented in *Yeager.* In reaching the same conclusion as the panel in *Yeager,* we reaffirm that decision today.

Given that the Plan clearly grants Aetna discretion to make benefits determinations, we have no occasion to reach the second en banc issue; whether the de novo standard of review announced in *Firestone* applies to the factual determinations made by Aetna.

V. CONCLUSION

The prior panel in this case reviewed Aetna's decision to terminate benefits under the de novo standard of review. Today we hold that the arbitrary and capricious standard should have been applied. Accordingly, we remand the case to the original panel to review Aetna's decision to terminate benefits under the arbitrary and capricious standard.

BOGGS, Circuit Judge, dissenting.

This case involves a straight-forward interpretation of the meaning of words. The Supreme Court has set out the standard in *Firestone:* does the document grant discretion to the plan administrator in making decisions under the plan? *See Firestone Tire & Rubber Co. v. Bruch* 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). Since the grant must be a clear and affirmative one, as the court correctly holds, *see* Majority Opinion at 555-556, it seems to me that the words at issue here, furnish "written proof," do not grant such discretion. I therefore respectfully dissent.

I

The court's opinion in this case carefully and correctly sets out the basic tenets of the law concerning the standard of review for decisions by the administrator of an ERISA plan to deny benefits to a claimant. *Firestone* requires that there be a grant of discretion to the administrator before such decision will be given the deference of the "arbitrary and capricious" standard of review. *See* Majority Opinion at 552 n. 1 (citing *Firestone,* 489 U.S. at 115, 109 S.Ct. 948). Otherwise, "*de novo*" review applies. *Ibid.* Under our decisions, that grant must be "clear." *See ibid.* at 555-556 (citing *Wulf v. Quantum Chem. Corp.,* 26 F.3d 1368, 1373 (6th Cir. 1994); *Tiemeyer v. Community Mutual Ins. Co.,* 8 F.3d 1094, 1099 (6th Cir. 1993)).

The majority also correctly notes that when the language of the plan clearly gives discretionary decision-making power to the administrator, courts have upheld such language. *See Miller v. Metropolitan Life Ins. Co.,* 925 F.2d

979, 983 (6th Cir. 1991) ("evidence satisfactory to the Insurance Company"); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) ("satisfactory to us"). Where the majority goes astray is in holding that the language in our plan is "similar" to such language, and thus is governed by the same principles. The court's opinion correctly concedes that the two types of language are dissimilar in a very important grammatical respect. One specifies to whom the proof must be satisfactory; the other does not. As the opinion notes, Aetna's language in our case lacks the crucial "indirect object." *See* Majority Opinion at 556, 557-558.

The court's opinion also (perhaps over-generously[1]) seems to concede that the cases finding discretion that it cites, *see* Majority Opinion at 555-556, all required the proof to be satisfactory to the administrator, and thus considers our case, in which no decision-maker is specified, as largely one of first impression.

The court errs in deciding that we may simply assume that the plan must mean that the proof is "satisfactory" to the administrator, for that is the only entity which could be the intended decision-maker. To me the difference between these two phrases, especially the difference to a sophisticated

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[1] *Caldwell v. Life Ins. Co.*, does involve a finding of a grant of discretion in a case where there is no indirect object or discretionary language. 959 F.Supp 1361 (D.Kan. 1997). *Patterson v. Caterpillar Inc.*, 70 F.3d 503, 505 (7th Cir. 1995), arguably does not have such language, though it does contain the stronger direction that the claimant must submit "such due proof as shall be . . . required. *See infra* pp. 560-561.

drafter, is enormous. When faced with the language "satisfactory proof" (or "written proof" or "due proof" or simply "proof"), the immediate response of any half-trained lawyer is "satisfactory to whom" (or, "proof" in whose judgment?). In this case, the Aetna drafter did not supply an answer, and it seems much more plausible that the default reading should be an objective standard, satisfactory to a neutral arbiter, or satisfactory in terms of the over-all meaning of the contract, rather than satisfactory to one of the two interested parties.

While individual ERISA plan participants generally have very little power over the exact terms of their plan, such plans are frequently negotiated in collective bargaining arrangements. In either instance, the worker or the worker's representatives might well find a significant difference between having their benefits determined wholly at the discretion of the plan administrator, usually a company chosen by the management of the plan, and having a neutral standard of proof. Reasonable participants reading the language of this plan would be quite unlikely to be on notice that they should be meticulous, and wary of the plan administrator, who will have enormous discretion.

II

The majority's argument based on the structure of the approval process proves too much. Every benefit plan requires the submission of some type of claim. The benefit administrator has to know that one claims benefits. Then the administrator has to match the claim against some type of standard and make a decision. There is no dispute about that. Even in *Firestone,* itself, the plan required that a claimant

apply for benefits when he or she is "physically or mentally unable to perform [his or her] job." *Firestone,* 489 U.S. at 105-06. 109 S.Ct. 948.

The question at issue here is whether in so doing, the administrator is held to an objective standard upon review, or is to be upheld unless a decision is not only objectively wrong, but also arbitrary and capricious. The majority's holding virtually eliminates the possibility of *de novo* review, unless the plan specifically says that *de novo* review will apply – the exact opposite of the result required by Firestone. *See Firestone*, 489 U.S. at 109, 109 S.Ct. 948. After all, how could there be a system in which benefits are claimed other than by applying to the plan administrator. *See Ayers v. Continental Cas. Co.*, 955 F.Supp. 50, 53 (W.D.Va. 1996).

The majority holding, resting as it does primarily on the nature of the application process, also underscores the weakness of its grammatical argument. "Evidence satisfactory to the Insurance Company," as in *Miller,* 925 F.2d at 983, or "evidence satisfactory to the committee," as in *Bali v. Blue Cross & Blue Shield Ass'n.* 873 F.2d 1043, 1047 (7th Cir. 1989), are clear. Indeed the concession in *Yeager,* noting that the language in that policy could be clearer, *see Yeager,* 88 F.3d at 381, and the majority's footnote 8 today, admonishing plan drafters, undercut the specific reasoning of *Yeager.* that there is "no meaningful distinction between" the two types of language ["submit proof that is satisfactory to us" v. "submit satisfactory proof of total disability to us."]. *Id.* at 380-81.

Finally, it is well to note that the key plan language here does not even require "satisfactory proof," as in *Yeager.*

Rather, it requires, the claimant to furnish "written proof," and only later states that the claimant must show "satisfactory evidence . . . that [he] *has furnished* all required proofs . . ." Majority Opinion at 555 (emphasis added). Obviously, if a claimant has submitted a claim with support that is objectively sufficient to prove the claim, that would have to be "satisfactory evidence" of his having furnished such proof. The nature of the proof required is itself qualified only by the term "written," and the grant of discretion, if there is to be one, must be carried simply in the language "written proof." Thus, only the majority's structural argument can possibly be a logical basis for its holding today.

III

The large majority of courts that have ruled on language that does not contain a referent as to who shall decide the quality of proof submitted have held that such language does not grant discretion, and have applied *de novo* review.

A very recent Ninth Circuit case, *Kearney*, is the clearest. *See Keaney v. Standard Ins. Co.*, 144 F.3d 597, 600 (9th Cir. 1998). There, a requirement of "satisfactory written proof" of loss was found not to create a discretionary standard of review. *Ibid.* at 605. The opinion specifically held that previous Ninth Circuit case, *Snow v. Standard Ins. Co.*, 87 F.3d 327 (9th Cir. 1996), did not dictate a discretionary standard of review, because the language in *Snow* ("proof satisfactory to the company") differentiated it from that in *Kearney* ("satisfactory written proof"), *Kearney*, 144 F.3d at 609-610. In so holding, the circuit chose between the decisions of two of its district courts – *Williamson v. Unum*

Life Ins. Co., 943 F.Supp. 1226 (C.D.Cal. 1996), which came to the same conclusion, and *Atkin v. Standard Ins. Co.*, No. C95-01176 FMS, 1069 WL 88814, at *1 (N.D.Cal. Feb. 16, 1996) which relied on *Snow* to find that such language granted discretion.

In *Bounds v. Bell Atlantic Enter.*, 32 F.3d 337, 339 (8th Cir. 1994), the 8th Circuit similarly held that "adequate proof of loss" did not confer discretion. This was confirmed in the more recent case of *Brown v. Seitz Foods, Inc.*, 140 F.3d 1198, 1199-1200 (8th Cir. 1998), which involved the phrase "due . . . proof of loss."

Additionally, clear decisions invoking *de novo* review were issued by district courts in the District of Massachusetts in *Cleary v. Knapp Shoes Inc.*, 924 F.Supp. 309, 312 (D.Mass. 1996) ("submit proof of loss"); the Southern District of New York in *Sarosy v. Metropolitan Life Ins. Co.*, No. 94-CIV-5431 (SHS), 1996 WL 426387, at *1 (S.D.N.Y. July 30, 1996) ("written proof of loss"); and the Western District of Virginia in *Ayers*, 955 F.Supp. at 53 ("due written proof of loss").

In the 4th Circuit case of *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017, 1020-22 (4th Cir. 1993), the court noted that both parties conceded that *de novo* review applied to language stating that the claimant must in accord with terms of the policy "file proof of loss."

The primary authority to the contrary appears to be the 7th Circuit's holding in *Patterson v. Caterpillar Inc.*, 70 F.3d 503, 505 (7th Cir. 1995), although the language there could be considered a bit stronger than in our case, in that the plan

stated that the claimant must file "such due proof as shall be . . . required." Feeling themselves bound by *Patterson*, district courts in the 7th Circuit have held similarly. *See Bollenbacher v. Helena Chem. Co.*, 926 F.Supp. 781, 786 (N.D.Ind. 1986) ("when the company receives proof"); *Infantino v. Waste Management, Inc.*, 980 F.Supp. 262, 266 (N.D.Ill. 1997) (provide proof" of disability). However, even within the 7th Circuit, in the case of *Lehmann v. UNUM Life Ins. Co.*, 916 F.Supp. 897 (E.D.Wis. 1996), the district court for the Eastern District of Wisconsin held that "satisfactory proof" did not confer discretionary review.

In fact, the *Caldwell* case, from the District of Kansas, is the only clear holding from an unfettered court that accepts the proposition that naked language requiring "proof," with or without some qualifier such as "due," "proper," or "satisfactory," is enough to be a clear grant of discretion to the plan administrator. *See Caldwell*, 959 F.Supp. at 1361.[2]

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[2] District courts within our own circuit, understandably at something of a loss for guidance following *Yeager, Perez*, and the en banc rehearing of *Perez*, have reached mixed results. Judge Gadola in the Eastern District of Michigan (pre-*Yeager)* held that "receives proof" of loss did not confer discretion, *Holsey v. UNUM Life Ins. Co.*. 944 F.Supp. 573, 576 (E.D.Mich. 1996); however, following *Yeager*, the same judge found that "satisfactory proof" did confer discretion. *Miller v. Auto-Alliance Int'l. Inc.* 953 F.Supp. 172, 175 (E.D.Mich. 1997). Judge Feikins, also in the Eastern District of Michigan, held that "due written proof of loss" did not confer discretion, *Warshaw v. Continental Cas. Co.*, 972 F.Supp. 428, 430 (E.D.Mich. 1997), as did Judge Bell in the Northern District of Ohio in *Ragsdale v. Unum Life Ins. Co.*, 999 F.Supp. 1016, 1017-18 (N.D.Ohio 1998), with respect to a simple

IV

Thus, based both on the ordinary rules of English and the large preponderance of authority from other federal courts, we should hold that the language in Aetna's policy does not grant to Aetna the type of discretion required by *Firestone*. I therefore respectfully dissent.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[Filed February 3, 1997]

No. 95-1111

BENITO T. PEREZ, JR.,
Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant-Appellee.

Before: MARTIN, Chief Judge, MERRITT, KENNEDY, NELSON, RYAN, BOGGS, NORRIS, SUHRHEINRICH, SILER, BATCHELDER, DAUGHTREY, MOORE, and COLE, Circuit Judges.

Prior report: 96 F.3d 813.

ORDER

A majority of the judges of this court in regular active service has voted to rehear the instant case *en banc*, having concluded that the following important issues, also presented and decided in *Yeager v. Reliance Standard Life Insurance*

Co., 88 F.3d 376 (6th Cir.1996), a case neither cited by the parties in this case nor considered by the panel, are at stake:

1. Whether the decision of the U.S. Supreme Court in *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 [109 S.Ct. 948, 103 L.Ed.2d 80] (1989), setting the standard for the review of an administrator's discretion in making ERISA plan decisions, encompasses decisions both of fact and of law, or whether the Supreme Court's decision should be limited only to setting standards with regard to an administrator's decisions of legal interpretation, while allowing unfettered discretion in all cases with respect to factual decisions.

2. Whether plain language stating that a plaintiff must "submit satisfactory proof . . . to us" gives the administrator broad discretion, just as it would if the language read "must submit proof that is satisfactory to us," see *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir.1991).

Sixth Circuit Rule 14 provides that:

> "The effect of the granting of a hearing *en banc* shall be to vacate the previous opinion and judgment of this court, to stay the mandate and to restore the case on the docket as a pending appeal.

Accordingly, IT IS ORDERED that the previous opinion and judgment of the court are vacated, the mandate is

stayed, and the case is restored to the docket as a pending appeal.

The clerk will direct the parties to file supplemental briefs addressing the two issues described above, and will schedule the case for oral argument June 11, 1997.

ENTERED BY ORDER OF THE COURT.

APPENDIX D

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[Filed September 23, 1996]

No. 95-1111

BENITO T. PEREZ, JR.,
Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant-Appellee.

OPINION

Before: JONES, BOGGS, and COLE, Circuit Judges.

BOGGS, Circuit Judge.

Benito T. Perez, Jr. appeals from the district court's grant of summary judgment to the Aetna Life Insurance Company (Aetna), on his claim under the Employee Retirement Income Security Act (ERISA). We resolve a split of authority among the district courts in the Sixth Circuit by joining those circuits holding that a *de novo* standard of review applies to both factual determinations and plan

interpretation determinations made by an ERISA plan administrator, unless the plan clearly gives a particular kind of discretion to the administrator. Applying this standard of review, we reverse the district court's grant of summary judgment to Aetna.

I

While working for the Motor Wheel Corporation, a division of Goodyear Tire and Rubber, Perez suffered a severe injury tn his heel and ankle when he jumped from a platform to escape an explosion of molten steel. Before his injury, Perez had worked for Motor Wheel for 16 years. At the time of his accident, Perez had only a limited education – a General Educational Development (GED) diploma obtained while he was in the military. Even so, Perez was earning $40,000 per year in 1971 as a production foreman. His accident occurred on November 24, 1984. Pursuant to the "Group Insurance Policy/Long Term Disability Benefits" (Plan) that Goodyear Tire & Rubber had negotiated with Aetna for the benefit of Goodyear employees, Perez was determined to be completely disabled and was granted disability benefits under the Plan beginning in December 1985. Perez is now 52 years old.

Michigan law requires its residents who are receiving unemployment benefits to obtain retraining where possible.[1]

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[1] Mich.Comp.Laws Ann. § 418.$19(a) (West 1995). The terms of the Plan also seem to contemplate that retraining should take place by using the term "become fitted by . . . training" in its definition of "reasonable occupation." Under the Plan, if a claimant can engage in a "reasonable occupation," he is no longer

In 1987, Perez, who was a feasible candidate for retraining at the community college level, entered a program leading to an associate's degree in business management from Lansing Community College. Perez's rehabilitation counselor sent Aetna a letter in which she noted that "[f]ollowing the completion of this program [for an associate's degree], job placement assistance will be provided until Mr. Perez has obtained employment." Perez did not obtain his degree until March 1991, two years behind schedule. Nevertheless, Aetna continued Perez's benefits through the entire period. Pursuant to a recommendation from his, rehabilitation counselor, Aetna informed Perez on April 8, 1991 that his benefits would be extended for a period of job placement not to extend past June 30, 1991.

Perez enrolled in a computer training course on June 24, 1991 that was scheduled to last 12 weeks. In a March 18, 1992 letter from Mid-Michigan Rehabilitation Associates, a rehabilitation counselor discussed Perez's "Amended Vocational Rehabilitation Plan" as follows[2]:

> Initial job placement efforts revealed that Mr. Perez needed computer skills to compete for entry-level jobs in the business field. His Business Management program at Lansing Community College did not include computer skills training, and with his prior work history comprised primarily of factory work, Mr.

"disabled."

[2] The district court and Aetna call this a "draft letter." It is unsigned, with only a typed name at the bottom.

Perez was not suitably prepared for an entry-level business position.

Since mid-June, 1991, Mr. Perez has been involved with an individualized, hands-on computer skills training program with Smith & Bell Computer Training Institute, Inc. in Lansing, Michigan. Having no prior knowledge of the keyboard, Mr. Perez had to develop basic keyboarding skills and is now working to increase his speed. He is also involved with the Basic WordPerfect instructional program and will then progress to Advanced WordPerfect and Lotus 1-2-3.

Per Ms. Rosario's [an employee of Aetna's] request, a copy of the Amended Vocational Rehabilitation Plan was provided to her, which outlines the additional training that Mr. Perez needs. I also explained to Ms. Rosario that the training period would likely go beyond the 12-weeks [sic] that the plan specifies because of Mr. Perez' lack of prior knowledge of the keyboard. The training program had to be further extended because of major medical problems experienced by Mr. Perez from December 1991 through March 1, 1992. . . .

In summary, it is my professional opinion that Mr. Perez was not yet competitively employable with the completion of his Associate Degree in Business Management. Had Mr. Perez already had employment

> experience in the business field in addition to possessing entry-level computer skills, he would have been much more readily employable following the completion of his degree in March 1991. However, in today's highly competitive job market. Mr. Perez is at a disadvantage without additional short-term training. It is my understanding that Mr. Perez' LTD [Long-Term Disability] Benefits were discontinued because of the assumption that he was employable with the Associate Degree in Business Management. However, for the reasons described above, Mr. Perez was not yet employable. Mr. Perez is working quite diligently in his computer skills program and has exhibited much enthusiasm for it. His vocational goal is customer service representative for a utility company or other similar business.
>
> * * *
>
> Susan M. O'Malley, M.Ed., CRC, LPC
> Rehabilitation Counselor

In response to Perez's requests for extension of his long-term disability benefits, Aetna wrote Perez on February 26, 1992 discontinuing his benefits:

> You . . . wrote us on September 9, 1991, and more recently on February 12, 1992. You are requesting an extension of Long-Term Disability benefit coverage in order that you may secure additional training and expertise involving the use of personal computers. You

> feel that this will enhance your marketability in job placement. We don't dispute that this additional training would be helpful but we feel that it is not essential in determining whether or not you presently have the training to pursue some reasonable occupation that others with the same training that you have are engaged in gainful work [*sic*]. We feel that you have acquired sufficient education and skills by virtue of your Associate of Arts Degree in Business Management and are now able to pursue some reasonable occupation. Therefore, we must refuse your request for extension of Long-Term Disability Benefits beyond June 30, 1991.
>
> Harvey McGee, Senior Analyst

McGee conceded at his deposition that he had no "particular vocational training," and would have to rely on Aetna's vocational expert, Leticia Rosario, in regard to such matters. Rosario stated in her deposition that she would defer to O'Malley's analysis of "whether or not Mr. Perez's capabilities in March of 1991 were competitive and marketable."

Concurrent with receiving benefits from Aetna, Perez collected Michigan worker's disability compensation benefits until December 5, 1992. On that day, he was offered employment at the Laboratory of Clinical Medicine of Michigan State University as a lab technician. He began to work there as a lab technician on December 7, 1992. He worked only one forty-hour week, then left work and never

returned. Perez sought reinstatement of his worker's compensation benefits. An administrative hearing on this matter was held before a Michigan worker's compensation disability magistrate on October 6 and October 11, 1993. Perez's request for reinstatement was denied on November 16, 1993 because the magistrate believed that Perez simply did not like the lab job, probably because he was averse to working with blood samples and feared contracting AIDS as a result.

The Plan defines "[t]otal disability" and "totally disabled" as "during the twelve month qualifying period and thereafter during any one period of disability, that the employee is unable, solely because of disease, accidental bodily injury or a pregnancy-related condition to work at any reasonable occupation." "Reasonable occupation" is defined as "any gainful activity for which the employee is, or may reasonably become, fitted by education, training, or experience, and in which other people of similar background are actually employed as their principal means of support." The Plan also requires that "[s]ubsequent written proof of the continuance of such disability must be furnished to [Aetna] at such intervals as [Aetna] may reasonably require. . . . [Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . (2) that [the claimant] has furnished all required proofs for such benefits. . . ." The Plan notes that,

> subject to adjustment for error, the determination and findings made in good faith

> by the Policyholder[3] with respect to (1) the fact and time of commencement, duration and termination of an employee's employment, lay-off, leave of absence, or other absence from work, (2) the monthly rate of basic earnings of any employee, and (3) any fact relating to any retirement plan of a Participant Employer, shall be conclusive and binding upon all persons for the purposes of this policy.

Aetna partially based its conclusion that Perez was not disabled under the Plan on a medical evaluation by Dr. Sara Ho:

> His current diagnosis will be including [*sic*] a calcaneous [*sic*] fracture, as well as triple arthrodesis.
>
> He reported that he had the impairment [*sic*] of his recreation activity, although does not [*sic*]] impair [*sic*] with his independence in self-care, daily activities. Based on my evaluation, patient is not completely unable to perform any occupation which they [*sic*] are reasonably suited by his education, training, or

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[3] Aetna argues that "Policyholder" refers to Aetna itself. However, the "Policyholder" in this case is clearly the Goodyear Tire & Rubber Company, as the Plan indicates. Aetna is referred to as the "Insurance Company" throughout the Plan. The term "Participant Employer" is also used throughout the Plan, but this likely refers to companies like Motor Wheel, Perez's former employer, which is a subdivision of Goodyear, not to Goodyear itself.

> experience. His current treating physician has given him a restriction of no lifting for 25-lbs. [*sic*], as well as no prolonged period of ambulation. I feel he could work within the restriction. I feel the patient is most suited to perform a sedentary type of occupation which does not require prolonged [*sic*] period of ambulation and standing, and patient should be able to return to work at this time with this guideline.

Perez filed a complaint under ERISA § 502(a)(1)(b), 29 U.S.C. § 1132(a)(1)(b), against Aetna on March 11, 1994, arguing that Aetna had denied benefits due to him under the Plan. On September 15, 1994, Aetna moved for summary judgment under Fed.R.Civ.P. 56(b). On. December 7, 1994, the district court granted summary judgment to Aetna, while denying Perez's cross-motion for summary judgment. The district court held that Aetna had correctly discontinued Perez's benefits under the Plan under either a *de novo* or "abuse of discretion" standard of review. The heart of the district court's opinion is set out below.

> Plaintiff appears to argue that he had to be able to "find employment," or that he had to be "competitively" employable, as mentioned in a draft letter that plaintiff cites that was apparently written by Ms. O'Malley. These statements concern the fact that plaintiff would likely benefit from computer training, making him even more employable. However, nothing in the disability policy requires that plaintiff be competitively employable or be

> actually able to find a job. Therefore, even if computer training was necessary for plaintiff to obtain a job in the actual competitive environment, this would not constitute a "disability" triggering benefits under the policy. As noted above, he need only be shown to be able to perform jobs that other people with similar education, training, and experience are performing.

The district court also noted that Aetna's readiness to extend benefits to Perez during a three-month period after his graduation so that he could engage in job placement, as well as its patience during Perez's slow progress toward an associate's degree, showed that Aetna was not acting in bad faith in denying further benefits to Perez.

Perez filed a motion with the district court to alter or amend the judgment under Fed. R.Civ. P. 59(e) on December 21, 1994. The district court denied this motion on January 9, 1995, as well as denying Aetna's motion for attorneys fees and costs. Perez filed a timely notice of appeal from the district court's grant of summary judgment to Aetna and from its denial of his motion to alter the judgment.

II. STANDARD OF REVIEW FOR RULE 59(e) MOTIONS

Denials of motions to alter or amend a judgment under Rule 59(e) are typically reviewed for abuse of discretion. But, where an appeal of the denial of such a motion is conjoined with an appeal from summary judgment, the same standard of review applicable to the district court's disposition

of the summary judgment motion should be employed in reviewing the Rule 59(e) motion. *Columbia Gas Transmission v. Limited Corp.*, 951 F.2d 110, 112 (6th Cir. 1991) (when a Rule 59(e) motion is being reviewed along with a grant of summary, judgment, *de novo* standard of review should be applied). Thus, when a party appealing from the denial of a Rule 59(e) motion is also appealing from either a grant or denial of summary judgment, the court does not review the denial of the Rule 59(e) motion separately.

In this case, because we must address a grant of summary, judgment, we will employ a de *novo* standard of review. *Parrett v. American Ship Building Co.*, 990 F.2d 854, 858 (6th Cir. 1993). The text of Rule 56(c) requires this court to determine whether there are any "genuine issues as to any material fact and [whether] the moving party is entitled to judgment as a matter of law." In making this determination, the court cannot resolve issues of fact, but must decide only whether there are issues in dispute to be determined in a trial on the merits. *Gutierrez v. Lynch*, 826 F.2d 1534, 1536 (6th Cir.1987). All reasonable inferences must be drawn from the facts in favor of the non-moving party, which in this case is the plaintiff, Perez. *Parrett* 990 F.2d at 858. A "mere . . . scintilla of evidence in support of the plaintiff"s position will be insufficient; there must be evidence on which [a] jury could reasonably find for the plaintiff." *Anderson v. Liberty Lobby*, 477 U.S. 242, 252, 106 S.Ct. 2505, 2511, 91 L.Ed.2d 202 (1986).

III. COLLATERAL ESTOPPEL

Aetna argues that because a worker's compensation magistrate in Michigan specifically found after a two-day

hearing that Perez could and did perform work at the Michigan State University's Laboratory of Clinical Medicine, Perez should be collaterally estopped from challenging Aetna's denial of additional ERISA benefits. It is difficult for us to consider Aetna's argument for collateral estoppel, because the district court did not address it in its opinion. "In general, an appellate court will not address issues on appeal that were not ruled upon below." *Maldonado v. National Acme Co.*, 73 F.3d 642, 648 (6th Cir.1996) (applying this rule to a claim for collateral estoppel).[4] Aetna contends that where summary judgment was correctly granted such a grant can be affirmed, even if for different reasons than those relied upon by the district court, citing *USA Petroleum Co. v. Atlantic Richfield Co.*, 13 F.3d 1276, 1279 (9th Cir. 1994). While a grant of summary judgment can typically be affirmed on different grounds, collateral estoppel is not such a ground,

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[4] For a forceful argument that courts of appeals should be able to raise preclusion issues sua sponte, even when the defendant did not plead them affirmatively in accordance with Fed. R.Civ. P. 8(c), see *Agg v. Flanagan*, 855 F.2d 336, 344 (6th Cir. 1988) (Contie, J., dissenting) (noting that the Court of Claims, the Eighth and Ninth Circuits, and even the Sixth Circuit in a per curiam opinion, had either addressed preclusion issues sua sponte or permitted a district court to raise preclusion issues sua sponte). The Second and Seventh Circuits also hold to the view espoused by Judge Contie's dissent in *Agg*. *See Studio Art Theatre of Evansville, Inc. v. City of Evansville*, 76 F.3d 128, 130 (7th Cir. 1996) (also noting that Second Circuit allows its district courts to raise preclusion issues sua sponte, citing *Salahuddin v. Jones*, 992 F.2d 447, 449 (2d Cir.), *cert. denied*. 510 U.S. 902, 114 S.Ct. 278, 126 L.Ed.2d 229 (1993)), *cert denied*. — U.S. —, 117 S.Ct. 177, — L.E.2d — (1996).

as *Maldonado* shows. *Maldonado* involved the review of a grant of summary judgment by a district court, but held nevertheless that collateral estoppel could not be addressed by our court unless it was raised below.

There is an exception to the general rule that the Sixth Circuit will not consider an issue not decided below, however, where "the proper resolution is beyond doubt" or "injustice might otherwise result." *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190, 194 (6th Cir. 1992). This is an extremely narrow exception that we infrequently invoke. We choose not to invoke it here because Aetna's state law-based argument for the application of collateral estoppel is doubtful.

It is true, as Aetna points out, that in non-diversity cases the federal law of collateral estoppel controls. *Blonder-Tongue Labs., Inc. v. University of Ill. Found.*, 402 U.S. 313, 324 n. 12, 91 S.Ct. 1434, 1440 n. 12, 28 L.Ed.2d 788 (1971). But federal law directs us to consult state law for the defining standards of preclusion where the prior judgment rests on state law, *See Marrese v. American Academy of Orthopaedic Surgeons*, 470 U.S. 373, 382, 105 S.Ct. 1327, 1332, 84 L.Ed.2d 274 (1985) (in a federal antitrust case, 28 U.S.C. § 1738[5] required that an earlier state court judgment

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[5] Section 1738 is the statutory counterpart of the constitutional Full Faith and Credit Clause, which applies only to the states. It reads as follows:

> [The] Acts, records and judicial proceedings or copies thereof, so authenticated, [of any State Territory or Possession] shall have the same full

be given the same preclusive effect that it would be given by a court of that state); *Migra v. Warren City Sch. Dist. Bd. of Educ.*, 465 U.S. 75, 81, 104 S.Ct. 892, 896, 79 L.Ed.2d 56 (1984) (same when federal claim based on 45 U.S.C. § 1983); *Stuhlreyer v. Armco, Inc.*, 12 F.3d 75, 77 (6th Cir. 1993) (same; ERISA claim); *Gutierrez v. Lynch*, 826 F.2d 1534, 1537 (6th Cir. 1987) (same; § 1983 claim). *See generally* Romualdo P. Eclavea, Annotation, *State or Federal Law as Governing Applicability of Doctrine of Res Judicata or Collateral Estoppel in Federal Court Action*, 19 A.L.R. Fed. 709 § 4 (1974 & Supp. 1995). *Cf. United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 99 S.Ct. 1448, 59 L.Ed.2d 711 (1979) (federal common law governing contractual liens arising from federal loan program incorporated state common law.) The only exception to this doctrine occurs where the statute on which the federal cause of action is based constitutes an express or implied repeal of § 1738. We find no evidence of such a repeal in ERISA.

Though we are not required to do so by the text of § 1738, federal common law requires us to give preclusive effect to the determinations of a state administrative agency acting in a judicial capacity. *University of Tennessee v. Elliott*, 478 U.S. 788, 106 S.Ct. 3220, 92 L.Ed.2d 635 (1986) (holding that federal courts must utilize the same preclusion doctrine as would be applied by a state court to administrative determinations by state; *Nelson v. Jefferson County, Ky.*, 863

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faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of such State, Territory or Possession from which they are taken.

F.2d 18, 19 (6th Cir. 1988) (same) *cert. denied*, 493 U.S. 820, 110 S.Ct. 76, 107 L.Ed.2d 42 (1989).

While federal law does not require mutuality between the parties, *Parklane Hosiery v. Shore,* 439 U.S. 322, 326-27, 99 S.Ct. 645, 649-50, 58 L.Ed.2d 552 (1979), some states do require mutuality. Michigan courts require mutuality of parties before giving issue-preclusive effect to a determination made by a Michigan state agency. *Nummer v. Treasury Dep't,* 448 Mich. 534, 553 N.W.2d 250, 253 (setting forth the requirements for giving issue-preclusive effect to administrative determinations and noting that mutuality is required), *cert. denied*, — U.S. —, 116 S.Ct. 418, 133 L.Ed.2d 335 (1995). *But see Knoblauch v. Kenyon,* 163 Mich.App. 543, 252 N.W.2d 286, 291 (1987) (arguing that in *Imperial Kosher Catering, Inc. v. The Travelers Indemnity Co.,* 73 Mich.App. 543, 252 N.W.2d 509 (1977), the Michigan Supreme Court had abandoned the mutuality requirement at least as it applied to defensive collateral estoppel (when a defendant uses collateral estoppel as a shield, not where a plaintiff uses it as a sword)). It is likely that *Nummer*, being the more recent pronouncement of the Michigan Supreme Court on the subject, correctly summarizes the law of Michigan, *Knoblauch* not withstanding. Even if this were not correct, however, the divergence of the two cases indicates that the law on whether mutuality is required in Michigan is not "beyond doubt" as *Meade* requires. Therefore, since Aetna was not a party to the Michigan worker's compensation proceeding where a magistrate determined that Perez could and did work, and since mutuality is or may be a requirement under Michigan law, we cannot hold that it is beyond doubt that a Michigan court would give that administrative determination preclusive effect.

Such certainty is required before we will address a collateral estoppel argument not dealt with by the district court below unless justice requires otherwise. As our resolution of the merits of this case below demonstrates, the equities here lie with Perez. Therefore, we refuse to resolve definitively the merits of Aetna's collateral estoppel argument.

IV. STANDARD OF REVIEW APPLICABLE TO DECISIONS BY AN ERISA PLAN ADMINISTRATOR

In the course of deciding whether to continue paying benefits under the Plan to Perez, however, Aetna needed to determine whether Perez was "disabled" under the Plan. Factual findings of this nature by a plan administrator can, under certain circumstances, be given a measure of deference by a federal court under *Firestone Tire & Rubber Co., v. Bruch,* 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed.2d 80 (1989). *Bruch* holds that where an ERISA plan administrator is explicitly given discretionary authority to determine eligibility for benefits or to construe the terms of an ERISA plan, then an abuse of discretion standard of review applies, although in all other circumstances a *de novo* standard of review should apply. The district court did not reach the issue of whether a *de novo* standard or an abuse of discretion standard applies in this case because it thought that whatever standard of review was applied the same result would obtain. In order to reach this issue, we must conclude that if a *de novo* standard of review were applied, we would reverse the district court. Since we think such a conclusion can be reached in this case, as we will demonstrate below in Section VI, we must decide whether a *de novo* or abuse of discretion standard of review applies here.

The parties dispute whether *Bruch* requires that the *de novo* standard of review must be applied to *factual determinations* made by a plan administrator, when an ERISA plan does not explicitly give its administrator discretionary authority to determine general benefits eligibility my making fact determinations. Aetna argues that *Bruch* only requires that the *de novo* standard of review we applied to the plan administrator's *interpretation of the terms* of an ERISA plan when an ERISA plan does not specifically confer this interpretive power. In Aetna's view, an ERISA plan administrator would always retain the power to make factual determinations absent, presumably, an express abnegation of this power in the terms of the plan. Perez argues that an ERISA plan must explicitly grant the power to make factual determinations, just as the plan must explicitly grant the power to interpret the provisions of the plan, to the plan administrator. Otherwise, Perez argues, *Bruch* requires that a *de novo* standard of review be applied to any factual determinations made by the plan administrator.

There is a circuit split on this issue. *Compare Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1559 (5th Cir. 1991) (abuse of discretion review always applies to factual determinations made by a plan administrator) *cert. denied* 502 U.S. 973, 112 S.Ct. 453, 116 L.Ed.2d 470 (White & Blackmun, JJ., dissenting) *with Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1183-84 (3d Cir. 1991) (*de novo* review applies to factual determinations made by a plan administrator unless the plan administrator has been explicitly given discretionary authority to determine eligibility for benefits); *Reinking v. Philadelphia Amer. Life Ins. Co.*, 910 F.2d 1210, 1214 (4th Cir. 1990) (applying *de novo* review to factual determination without

addressing controversy over how to interpret *Bruch*), *overruled on other grounds by Quesinberry v. Life Ins. Co. of N. Amer.*, 987 F.2d 1017 (4th Cir. 1993) (en banc); *Petrilli v. Drechsel*, 910 F.2d 1441, 1446 (7th Cir. 1990) (noting in dicta that the Supreme Court's statement of its holding in *Bruch* "strongly suggests" that the Court intended to require the application of *de novo* review if a plan administrator had not been explicitly given the relevant type of discretion, regardless of whether interpretative or factual determinations were being reviewed).

Moreover, the district courts within the Sixth Circuit are also split. *Compare Moshin v. John Hancock Mut. Life Ins. Co.*, C.A. No. 88-CV-60415-AA (E.D Mich. Nov. 27, 1989) (La Plata, J.) (applying arbitrary and capricious standard of review because plaintiff's claim involved only a factual determination)[6] ; *Fauver v. The Travelers Indemnity Co. of R.I.*, Civ. Action No. 90-CV-40118-FL (E.D.Mich. Nov. 27, 1990) (Newblatt, J.) (canvassing the law in the area and concluding in dicta that abuse of discretion review always applies to factual determinations made by a plan administrator) *with Donaldson v. Metropolitan Life Ins. Co.*, 812 F.Supp. 103, 105 n. 5 (E.D Mich. 1993) (Zatkoff, J.) (*de novo* standard of review applies to ERISA benefit denials based on either plan interpretation or purely factual determinations, absent an explicit grant of discretionary authority to the plan administrator); *Reynolds v. Massachusetts Casualty Ins. Co.*, 900 F.Supp. 915, 924 n 8 (E.D.Tenn. 1995) (same,

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[6] Aetna represents that *Moshin* was affirmed by the Sixth Circuit, but an appeal from this decision was in fact voluntarily dismissed by stipulation of the parties involved.

rejecting defendant's invocation of the Fifth's Circuit's *Pierre* decision).

The Sixth Circuit has not squarely addressed this issue before. Nevertheless, conflict exists between dicta in certain Sixth Circuit cases and the results of other Sixth Circuit cases. *Compare Davis v. Kentucky Finance Cos. Retirement Plan,* 887 F.2d 689, 693-94 (6th Cir. 1989) (possibly limiting, in dicta, *de novo* review to plan interpretation issues by portion of *Bruch* it chose to quote; *Davis's* dicta seems to have led to the *Moshin* decision summarized above), *cert. denied*, 495 U.S. 905, 110 S.Ct. 1924, 109 L.Ed.2d 288 (1990); *Aubrey v. Aetna Life Ins. Co.*, 886 F.2d 119, 122 (6th Cir. 1989) (same) *with Anderson v. Great West Life Assur. Co.,* 942 F.2d 392, 395 (6th Cir.1991) (plan administrator can be given discretionary authority with respect to some decisions, but not others; unless discretionary authority clearly granted, *de novo* standard of review must be applied); *Brown v. Ampco-Pittsburgh Corp.*, 876.F.2d 546, 550 (6th Cir.1989) (applying *de novo* standard of review to factual determination without noting controversy over this choice).

This dispute over the breadth of *Bruch* results because Justice O'Connor's opinion in that case stated the question presented in a very limited fashion at one point: "The discussion which follows is limited to the appropriate standard of review in [29 U.S.C.] § 1132(a)(1)(B) actions challenging denials of benefits *based on plan interpretations.*" *Bruch*, 489 U.S. at 108, 109 S.Ct. at 953 (emphasis added). Aetna and the Fifth Circuit in *Pierre* take this language to mean that the ultimate holding of the case, requiring *de novo* review to be applied to benefit denials where a plan does not explicitly grant the plan's administrator discretionary authority to make

benefits determinations, is limited to "plan interpretations" only. Thus, the implicit limitation on the holding of *Bruch* that Aetna urges this court to adopt is that fact determinations made by a plan administrator are outside of *Bruch's* holding, and thus become subject to abuse of discretion or arbitrary and capricious review.

Looking to the facts of *Bruch*, to the language the Supreme Court used elsewhere in the case, and to the case's reasoning, the argument made by Aetna is weak. In *Bruch*, employees who were terminated by their former employer and rehired by a successor corporation brought suit under ERISA § 1132(a)(1)(B) against that corporation to obtain severance benefits they alleged were wrongfully denied them by their former employer. Their former employer argued that the employees were not terminated because of a "reduction in work force" and therefore under the terms of the Plan the employees were not entitled to severance benefits. The Third Circuit held that the former employer's denial of severance benefits was to be reviewed *de novo* because, in situations where an employer is the plan administrator, deference is unwarranted given the lack of impartiality on the employer's part. Because the ERISA plan at issue did not give the former employer discretion to make benefits determinations, the Supreme Court held that *de novo* review was appropriate, but it noted that the impartiality of a plan administrator could be considered when it becomes necessary to apply abuse of discretion review. The Court disagreed with the Third Circuit's use of impartiality as a factor to be employed in making the determination of whether the terms of an ERISA plan require the application of *de novo* or abuse of discretion review.

The Court rejected the argument that the background principles of trust law that inform ERISA require that abuse of discretion review always be applied to challenges based on allegedly improper denials of benefits under § 1132(a)(1)(B). "As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation." *Bruch*, 489 U.S. at 112, 109 S.Ct. at 955. In short, the Supreme Court's rationale for rejecting the plan administrator's argument in *Bruch* was that a trust, and therefore an ERISA plan, was like any other contract – courts should not give any deference to either party's interpretation of the contract, unless the terms of the contract itself required that such deference be shown.

> Actions challenging an employer's denial of benefits before the enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim – by looking to the terms of the plan and other manifestations of the parties' intent.

Id. at 112-13, 109 S.Ct. at 955. "Adopting [the employer's] reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 113-14, 109 S.Ct. at 956.

Under the Supreme Court's reasoning, the argument by Aetna and the Fifth Circuit that *Bruch* does not require the

application of *de novo* review to factual determinations made by plan administrators in the absence of a grant of discretionary authority to the plan administrator is puzzling. Facts relating to the interpretation of both trust and non-trust contracts cannot be determined by one of the parties to that trust or contract dispute, unless that power is explicitly given in the trust or contract. The baseline principle of our system of law is that *courts* resolve disputes about contracts, trusts, and ERISA plans, whether those disputes are factual or based on the terms of the relevant instrument. Moreover, the Supreme Court, in its brief survey of trust and contract law in *Bruch*, did not distinguish between the appropriateness of deference to factual findings and the interpretation of the terms of a contract or trust.

The reasoning in the Fifth Circuit's *Pierre* decision to the contrary is conclusory. The *Pierre* court first noted that as a policy matter it would not be inconceivable to apply different standards of review to factual determinations and interpretations of a plan's language. *Pierre*, 932 F.2d at 1557-59. The court then concluded that, "[t]he courts simply cannot supplant plan administrators, through *de novo* review, as resolvers of mundane and routine fact disputes." *Id.* at 1559. Here, the Fifth Circuit appears to be arguing that resolving factual disputes in ERISA cases would be too wasteful an exercise for a federal court to engage in. Much the same could be made in many of the diversity cases that the federal courts are required to hear, however. This argument ignores the lesson of *Bruch*, which is that an employee cannot be forced to accept the resolution of "mundane and routine fact disputes" about benefit eligibility made by the plan administrator, unless the plan itself grants this discretionary authority to the plan administrator. The *Pierre* court's

argument proves too much because if accepted it would require the federal courts to grant deference to any mundane factual determination made by one party to a contract, even if the contract did not give fact-finding power to one of the parties.

The *Pierre* court also noted that the factual determinations at a prior stage of litigation are usually reviewed deferentially by federal courts. *Id.* at 1558. This, of course, is true, but the reason for applying deference in such circumstances is either that the courts of appeals are reviewing the district courts in their capacity as finders of fact, or that the federal courts are reviewing administrative agencies engaging in a similar function. Deferring under these circumstances is very different than deferring to a plan administrator, who will be one party to a private dispute, when the administrator is purporting to act as a fact-finder under a plan that does not explicitly grant such authority. The baseline principle is that a federal court cannot be expected to defer to a plan administrator in such situations. The reason for treating the two situations differently is obviously that one party to a contract has an incentive to find facts not in a neutral fashion, but in the manner that is most advantageous to its own interests. The Supreme Court rejected similar reasoning by the Third Circuit in *Bruch* only insofar as the Third Circuit seemed to be saying that *de novo* review would apply even when a plan explicitly gave interpretive or fact-finding power to a plan administrator. Obviously, if a trust's terms give fact-finding power to a plan adminismtor, a federal court must respect that allocation of authority regardless of whether, once such terms are in place, the plan administrator could use the fact-finding power to its own advantage. An ERISA plan with a term in it granting discretionary authority

to the plan administrator to find facts or to interpret the language of the plan may be worth less to an employee than a plan that does not include a grant of such discretionary authority. The ability to take even a "mundane and routine" factual dispute to a federal court for resolution is obviously valuable to employees. To strip this value out of an ERISA plan is to "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Bruch*, 489 U.S. at 114, 109 S.Ct. at 956.

The *Pierre* court relied on certain aspects of the legislative history of ERISA even while recognizing that reliance on this legislative history had been rejected by the Supreme Court in *Bruch*: "We acknowledge that the Supreme Court in *Bruch* rejected these justifications for plan term interpretations. We believe, however, that in the area of reviewing factual determinations, these justifications for a deferential standard of review remain valid and compelling." *Pierre*, 932 F.2d at 1558 n. 8. The Supreme Court, however, found the same legislative history cited in *Pierre* less than compelling because it was subsequent legislative history – "[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *Bruch*, 489 U.S. at 114, 109 S.Ct. at 956 (quoting *United States v. Price*, 361 U.S. 304, 313, 80 S.Ct. 326, 332, 4 L.Ed.2d 334 (1960)). There is no reason to limit this rationale only to congressional intent with respect to plan interpretation issues. Its general applicability forces the conclusion that it was intended to cover factfinding determinations.

The most significant argument of the *Pierre* court is that 29 U.S.C. §§ 1102(a)(1)[7] and 1133(2)[8], in conjunction with the Restatement (Second) of Trusts § 186[9], mean that fact-finding by a plan administrator should always receive

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[7] 29 U.S.C. § 1102(a)(l) provides as follows:

> Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly and severally shall have the authority to control and manage the operation and administration of the plan.

[8] 29 U.S.C. § 1133 provides, in relevant part:

> In accordance with the regulations of the Secretary, every employee benefit plan shall--
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> * * *
>
> (2) afford a reasonable, opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

[9] Restatement (Second) of Trusts § 186 provides as follows:

> Except as stated in §§ 165-168, the trustee can properly exercise such powers and only such powers as
>
> (a) are conferred on him in specific words by the terms of the trust, or
>
> (b) are necessary and appropriate to carry out the purposes of the trust and are not forbidden by the terms of the trust.

deferential review. *Pierre,* 932 F.2d at 1557-58. We first examine the court's argument from the Restatement. Section 186 of the Restatement does not provide any support for *Pierre's* conclusion. The *Pierre* court focuses on § 186(b), which, uses the phrase "necessary and appropriate," for the purpose of contending that fact-finding is a necessary and appropriate power for an ERISA plan administrator to possess. This argument ignores the Supreme Court's focus in *Bruch* on the point of law expressed in § 186(a) of the Restatement, which notes that a trustee lacks powers unless they are specifically conferred. We do not understand why it "necessary" for a plan administrator to have the discretionary power to determine facts when disputes arise relating to the ERISA plan being administered. Moreover, the plan administrator's § 186(b) powers only exist to "carry out the purposes of the trust" and must not be "forbidden by the terms of the trust." We read these limitations in conjunction with § 186(a), which requires "specific words" in the trust conferring a particular power on the trustee. Section 186(b) confers all means necessary to achieve the powers specifically conferred on a plan administrator, but it does not grant the plan administrator entirely new powers. The power to determine facts in the first instance is significant enough to require an express grant in the terms of the plan. *Pierre* cites no cases to support its novel reading of § 186(b).

Therefore, the *Pierre* court is left with its arguments from 29 U.S.C. §§ 1102(a)(1) and 1133(2). Similarly, the *Pierre* court provides no citations to support its conclusion that the "authority to control and manage the operation and administration of the plan" or "full and fair review" includes the power to find facts. Most importantly, the Supreme Court rejected arguments from both of these statutory provisions in

Bruch: "But the provisions relied upon so heavily by [the plan administrator] do not characterize a fiduciary as one who exercises entirely discretionary authority or control. Rather, one is a fiduciary to the extent he exercises any discretionary authority or control." *Bruch*, 489 U.S. at 113, 109 S.Ct. at 955-56. Again, the touchstone of the analysis in *Bruch* is the terms of the plan and the discretion it explicitly grants or fails to grant to the plan administrator.

We reject the conclusion and reasoning of *Pierre*. We join every other circuit that has either explicitly or implicitly addressed this question. *Bruch* does not distinguish between fact-finding and plan term interpretation. "Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits [fact-finding] or to construe the terms of the plan [plan interpretation]." *Bruch* 489 U.S. at 115, 109 S.Ct. at 956-57.

V. THE PLAN DOES NOT GIVE AETNA DISCRETIONARY AUTHORITY

Perhaps recognizing the problems with its reliance on *Pierre*, Aetna argues that it has been explicitly given discretionary authority in the Plan to make benefits determinations. To support this claim, Aetna points to the following language in the Plan: "[s]ubsequent written proof of the continuance of such disability must be furnished to [Aetna] at such intervals as [Aetna] may reasonably require. . . . [Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . (2) that [the claimant] has

furnished all required proofs for such benefits.[10] It is true that "[t]he Court in *Firestone [v. Bruch*] surely did not suggest that 'discretionary authority' hinges on incantation of the word 'discretion' or any other 'magic word.' Rather, the Supreme Court directed lower courts to focus on the breadth of the administrators' power – their 'authority to determine eligibility for benefits or to construe the terms of the plan.'" *Block v. Pitney Bowes, Inc*, 952 F.2d 1450, 1453 (D.C.Cir.1992) (quoting *Bruch*, 489 U.S. at 115, 109 S.Ct. at 956-57). However, the plan meaning of the provisions Aetna cites from the Plan does not give it discretionary authority. First, simply because Aetna has the ability to require written proof before continuing disability benefits

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[10] We note that the following provision in the Plan, also cited by Aetna, provides no support for its argument:

> Subject to adjustment for error, the determination and findings made in good faith by the Policyholder with respect to (1) the fact and time of commencement, duration and termination of an employee's employment, lay-off, leave of absence, or other absence from work, (2) the monthly rate of basic earnings of any employee, and (3) any fact relating to any retirement plan of a Participant Employer, shall be conclusive and binding upon all persons for the purposes of this policy.

As discussed *supra*, p. 818 & n. 3, Aetna is not the "Policyholder" and therefore this provision which gives conclusive power to Goodyear to determine certain facts not relevant here, offers no basis for arguing that Aetna has been given any discretionary authority either to interpret the Plan or to make benefits determinations.

does not mean that Aetna has the discretionary authority to decide whether that proof is sufficient within the meaning of the Plan. Second, simply because Aetna may require "satisfactory proof" does not give the insurance company discretionary authority, either. The quoted Plan provision does not specify to whom the proof should be satisfactory. Perez is probably correct in arguing that this language creates an objective standard – proof "satisfactory" to a reasonable person. But all we need decide at this point is that the language does not clearly give Aetna discretion, which is what the language of an ERISA plan must do under *Bruch* to trigger abuse of discretion review.

To overcome this commonsensical conclusion, Aetna cites a number of cases, all of which are distinguishable. *See Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379-80 (7th Cir. 1994) ("all proof must be satisfactory to us"); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637 (5th Cir.1992) (plan allowed administrator to "make an independent determination of the applicant's eligibility for benefits under the Plan" and noted that the administrator's decision "shall be final and conclusive upon all persons. . . ."); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir.1991) (plan used the phrase "on the basis of medical evidence satisfactory to the Company"); *Sisters of the Third Order of St. Francis v. SwedishAmerican Group Health Benefit Trust*, 1369, 1371 (7th Cir. 1990) (plan gave committee power to "construe and interpret the Plan [and] decide all questions of eligibility")[11]; *Davis*, 998 F.2d

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[11] *Sisters of the Third Order* holds that under either an abuse of discretion or *de novo* standard of review a claimant could

at 694 (plan used the phrase "[i]n case of any factual dispute hereunder, the Requirement Committee shall resolve such dispute giving due weight to all evidence available to it"); *de Nobel v. Vitro*, 885 F.2d 1180, 1186-87 (4th Cir. 1989) ("the Committee shall have such powers . . . including . . . the power . . . [t]o determine all benefits and resolve all questions pertaining to the administration, interpretation and application of Plan provisions, either by rules of general applicability or by particular decisions"); *Bali v. Blue Cross and Blue Shield Assoc.*, 873 F.2d 1043, 1047 (7th Cir. 1989) ("'disabled' means that a Participant is, determined on the basis of medical evidence satisfactory to the Committee, wholly prevented, by reason of mental or physical disability, from engaging in any occupation"); *Kiley v. The Travelers Indemnity Co. of R. I.*, 853 F.Supp. 6, 11 (D.Mass. 1994) (plan used the phrase "the Employee shall be assumed to be totally disabled if because of disability he is unable (as determined by the Company) to perform the normal duties of his regular occupation") Aetna also cites *Pressley v. Metropolitan Life Ins. Co.* 729 F.Supp. 570, 572 N. 1 (E.D. Mich. 1990), but it is not possible to know why the *Pressley* court concluded that discretion existed, as the exact language of the plan was not quoted in its opinion. Moreover, even if vague language was held in *Pressley* to confer discretionary authority upon a plan administrator to resolve factual disputes, that district court

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not prevail because of a provision in the relevant ERISA plan barring recovery of benefits for injuries that occurred while engaging in illegal activity. The intoxicated claimant in *Sisters of the Third Order* was injured while driving an automobile. This case does not hold that the language of the ERISA plan at issue was sufficiently clear to confer discretion on the plan administrator in light of *Bruch*, however.

result is not persuasive in the fact of substantial contract authority from the courts of appeals and other district courts.

In response to Perez's argument that the cases Aetna has cited are clearly distinguishable from this case, because the language of the plans considered on those cases was different and much clearer, Aetna ironically claims that Perez provides no authority for this conclusion. If Aetna means that Perez cited no cases holding that language similar to its Plan failed to confer discretionary authority, then Aetna is undoubtedly correct. However, *Bruch* requires that discretion must be granted in an ERISA plan in order for abuse of discretion review to apply. A court determines whether discretion has been granted by reading the plan. Reading the Plan in this case leads to the ineluctable conclusion that discretion was not granted. Thus, Perez needs no more authority to make this point than *Bruch* itself. Perez is not arguing that the Plan did not use the magic word "discretion;" he is arguing that it did not use any words to indicate clearly that fact-finding discretion was being granted to Aetna.

We conclude that based on the language of the Plan at issue in this case a *de novo* standard of review is applicable to Aetna's decision to discontinue Perez's benefits under the Plan.

VI. APPLICATION OF *DE NOVO* STANDARD OF REVIEW

The Plan defines "Total disability" and "totally disabled" as "during the twelve month qualifying period and thereafter during any one period of disability, that the employee is unable, solely because of disease, accidental

bodily injury or a pregnancy-related condition to work at any reasonable occupation." Other than the determination of whether he is "unable . . . to work at any reasonable occupation" because of his injury, it is obvious Perez meets the requirements of this provision. "Reasonable occupation" is defined as "any gainful activity for which the employee is, or may reasonably become, fitted by education, training, or experience, and in which other people of similar background are actually employed as their principal means of support." Aetna concedes that Perez was unsuited before he completed his associate's degree for any "reasonable occupation." The crux of the case is therefore whether, after he obtained his associate's degree (after he became "fitted by education"), Perez was able to engage in some gainful activity "in which other people of similar background are actually employed as their principal means of support."

The plain meaning of the requirement that Perez be able to engage in gainful activity "in which other people of similar background are actually employed as their principal means of support" is that Perez: (1) be capable of working at a job where individuals with similar education, training, or experience were actually working; and (2) that such jobs provide the principal means of support for such individuals. This is because the referent of the term "background" is "education, training, or experience." Thus, Perez's argument that Aetna would have to show that someone with an associate's degree from Lansing Community College who had the same injuries Perez had to his or her heel and ankle was working as, for example, a customer service representative at a bank must be rejected. "Background" does not refer to a similar physical or mental impairment, but, in context, refers to similar education, training, or experience. Perez's

suggestion at various points throughout his briefs that "reasonable occupation" requires him to be able to find a job comparable perhaps in salary and status to his former employment at Motor Wheel is also without support in the Plan language.[12]

The district court's assessment of the Plan's "reasonable occupation" language has its own difficulties: "However, nothing in the disability policy requires that plaintiff be competitively employable or be actually able to find a job." While it is true that the language in the Plan does not mandate that Perez actually find a job, it does mandate, contrary to what the district court stated, that Perez *be able* to find a job. If Perez were not able to find a job, then he would not be "fitted" to engage in some "gainful activity." The district court was correct in noting, however, that there is no requirement in the Plan's language that Perez be "competitively employable." Thus, that part of the letter from vocational expert O'Malley opining that Perez was not "competitively employable" without additional computer training does not bear on Perez's claim one way or the

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[12] Moreover, although irrelevant from a legal standpoint, it is relevant from an equitable standpoint that Perez was entitled to receive from his former employer under Michigan law 80% of the difference between the salary, of any job he now obtains and his salary on the date of his injury. Mich.Comp.Laws Ann. § 418.301(5)(b) (West 1995). Maximum benefits received under this provision, however, could not have exceeded the maximum weekly rate of compensation as determined in Mich.Comp.Laws Ann. § 418.335 (West 1995).

other.[13] One obvious interpretation of O'Malley's statement, taken in isolation, is that Perez may have been employable without the computer course, but that he would have had a hard time finding employment in those circumstances. At another point, however, O'Malley opined more definitively that "for the reasons described above, Mr. Perez was not yet employable." In context, O'Malley may be doing nothing more than reiterating her earlier opinion that Perez is not "competitively employable." The unqualified statement, on the other hand, may mean that O'Malley thinks that "competitively employable" was just another way of saying "employable." Indeed, Perez makes an argument that the two terms are identical. We are forced to conclude that O'Malley's intended meaning is ambiguous.

Aetna places heavy reliance on various medical opinions that basically conclude Perez is capable of performing some kinds of sedentary work. The Plan,

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[13] Aetna is arguing that the O'Malley letter must be ignored because it was unsigned. Of course, Perez is clearly representing that the letter is genuine. Any conflict over the authenticity of the letter, to the extent it is material to the resolution of this appeal, is inappropriate for resolution on summary judgment. Therefore, according to the standard of review we are applying to the district court's decision, we must presume that the letter is authentic for the purposes of this appeal. Aetna also argues that the letter was a draft and that a very different final letter was sent. Again, we must, at the summary judgment stage of this litigation, take the letter at face value because there is a dispute about its significance. Therefore, we ignore the possibility that the draft letter may not truly express O'Malley's opinion of the vocational options open to Perez.

however, requires that Perez be able to engage in gainful activity to which he is suited by means of his education, training, or experience. These are matters not within the province of the medical experts Aetna relies upon. Perez requests that we hold that the language of the Plan requires Aetna to solicit vocational expert testimony determining which "reasonable occupations" are actually available to a claimant before denying benefits. There may be other ways to meet the "reasonable occupation" test set up by the Plan[14], however, so we do need not go as far as Perez requests.

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[14] For instance, if Perez had worked at the Laboratory of Clinical Medicine of Michigan State University as a lab technician before Aetna made the determination to discontinue his benefits, and Aetna had been aware of this fact, Aetna may have been on much stronger ground. However, Perez did not obtain this job until after Aetna discontinued his benefits, and so obviously Aetna could not have known he would find this job. *See McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 431 n. 1 (6th Cir. 1989) (noting that "'[a] federal court is to focus on the evidence before the trustees at the time of their final decision and is not to hold a *de novo* factual hearing,'" although suggesting that this rule should be reconsidered now that *Bruch* has been decided) (quoting *Crews v. Central States*, 788 F.2d 332, 336 (6th Cir. 1986), quoting *Wardle v. Central States*, 627 F.2d 820, 824 (7th Cir. 1980), *cert. denied*, 449 U.S. 1112. 101 S.Ct. 922, 66 L.Ed.2d 841 (1981)); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (taking up *McMahan's* invitation to test the validity of *Crews* in light of *Bruch*, and holding that for various policy reasons *Crews* is sound even after *Bruch*). Moreover, the evidence relating to Perez's employment by Michigan State University, which is the basis for the worker's compensation magistrate judge's opinion, is not in the record, since Aetna presented the district court only with a copy of this opinion.

Nevertheless, we conclude, after applying a *de novo* standard of review to the meaning of the language of this Plan, that when a claimant produces evidence from a vocational expert that may support the conclusion that the claimant was not employable and such evidence is unrefuted by any contrary vocational evidence, the claimant has shown enough to resist a grant of summary judgment to the plan administrator, under § 1132(a)(1)(B).[15]

---

[15] Our resolution of this issue allows us to avoid taking a position with regard to another split among the circuits in relation to the question of whether plan administrators must consult with vocational experts when making determinations about a claimant's employability. *Compare Gunderson v. W.R. Grace & Co. Long Term Disability v. Income Plan,* 874 F.2d 496, 499 (8th Cir. 1989) (before terminating disability income benefits plan administrator should have obtained vocational expert's opinion to determine if employee was presently capable, in light of his physical impairment, to perform "any occupation") *with McKenzie v. General Tel. Co. of Cal.,* 41 F.3d 1310, 1317 (9th Cir. 199a) ("we hold that consideration of vocational evidence is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job"), *cert. denied.* -- U.S. --, 115 S.Ct. 1697, 131 L. Ed.2d 500 11995): *Duhon v. Texaco, Inc.,* 15 F.3d 1302. 1309 (5th Cir. 1994) (not an abuse of discretion for plan administrator to fail to consider vocational evidence in connection with plan having language similar to Aetna's Plan in this case); and *Block,* 952 F.2d at 1455 (no need for plan administrator to provide vocational evidence of jobs where plan used phrase "reasonably fitted by education, experience, capability or training").

Aetna argues that it does have the opinion of a vocational expert, in the form of the letter from Perez's vocational expert, noting that "[f]ollowing the completion of this program [for an associate's degree], job placement assistance will be provided until Mr. Perez has obtained employment." Aetna consistently characterizes this as a representation that Perez was "ready" for "job placement." First, this is not what the letter says. Second, even if it did, being ready for attempted "job placement" and being "employable" are arguably two different matters, particularly if the vocational counselor who wrote this letter did not realize at the time that Perez lacked uecessary computing skills.

The district court seems to have recognized many of the problems with granting summary judgment to Aetna in this case in its opinion addressing Perez's Rule 59(e) motion:

> [T]he amount of evidence provided to support defendant's position was surprisingly little. As noted by plaintiff, there was no specific showing of another person with plaintiffs limitations and skills actually performing a reasonable occupation. Also, there was no actual statement by a vocational expert that there were reasonable jobs being performed by similarly situated individuals with similar disabilities. Therefore the relative merits of the case were not overwhelmingly in favor of defendant.

As noted above, there was no need for Aetna to show that someone with Perez's disabilities was actually employed in a

job that Perez was fitted to by means of his education, training, or experience. (Although, if a person with Perez's disabilities would not be able to perform a particular job, then Perez would be physically unable to perform such a "reasonable occupation," and therefore be "disabled" under the Plan.) However, Aetna did need to show under the language of the Plan that someone with Perez's "skills" (training and experience), or "education" was actually performing a "reasonable occupation."

The definition of "reasonable occupation" in this Plan imposes three conditions that must be met before a claimant under the Plan who is otherwise disabled ceases being disabled: (1) the claimant must be fitted by education, training, or experience to perform a particular job; (2) someone of similar education, training, or experience must actually be performing such a job; (3) those people performing that job must be using it as their principal means of support.[16] Here, the only evidence Aetna presented and the district court relied on to satisfy the first requirement is really an argument – someone with an associate's degree from a community college must be able to work at some job. As a general matter, this is probably not an unreasonable

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[16] Because Perez prevails on a plain meaning construction of the Plan's terms, there is no need to address his argument that the court should apply the canon *of contra proferentum* to its interpretation of the Plan. *See Edwards v. Slate Farm Mut. Auto. Ins. Co.*. 851 F.2d 134, 136 (6th Cir, 1988) (statements in plan summary are binding even if they conflict with language of plan itself): *Sprague v. General Motors Corp.*, 843 F.Supp. 260, 307 (E.D.Mich. 1994) ("benefit plan ambiguities must be construed in the employees' favor," citing *Edwards).*

assumption, but it is possible that some educational institutions, even community colleges, which generally focus more than liberal arts colleges on equipping their students with marketable skills, may produce some graduates who simply are simply not employable. Furthermore, even if other graduates of the same program Perez went through at Lansing Community college have managed to find employment, the computer skills that O'Malley asserts that Perez needs to obtain employment may have been obtained by those other Lansing graduates outside of their formal instruction at Lansing. Many younger students acquire in high school or computing at home as a hobby the basic computer skills O'Malley claims Perez needs.

To protect its grant of summary judgment when the *de novo* standard of review applies, Aetna has to do more than simply invite this court to make a plausible assumption. There is no evidence in the record to support the conclusion that people with an associate's degree from Lansing are employable simply because they hold such a degree. Moreover, there is no evidence in the record to support the conclusion that the second and third requirements of the definition of a "reasonable occupation" in the Plan are met. Aetna has no evidence from which it could conclude that there is any job being performed by someone of Perez's education, training, or experience. Indeed, Aetna cannot point to any particular job (other than the lab technician job that we must ignore, given our refusal to address Aetna's collateral estoppel argument) that Perez can perform. Aetna's argument is that it does not need to point to any specific job. This is a misinterpretation of the terms of the Plan. Finally, Aetna has not offered any evidence from which one could conclude that there is some specific job from which those with a similar

background to Perez are drawing their principal means of support.

Under a *de novo* standard of review, the district court's grant of summary judgment to Aetna must be reversed. There is undisputed evidence in the record that could be read to support the conclusion that Perez is not employable. Most importantly, the Plan administrator, Aetna, has presented no evidence to support its conclusion that Perez could engage in a "reasonable occupation" simply because he obtained an associate's degree. Genuine issues of material fact preclude summary judgment in this case.

VII

We **REVERSE** the district court's grant of summary judgment to Aetna and **REMAND** for the district court to conduct further proceedings in this case in accordance with this opinion.

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

[Filed December 7, 1994]

No. 5:94:CV:42

BENITO T. PEREZ, JR.,
Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant.

OPINION

This matter is before the Court on defendant's motion to dismiss and for summary judgment and plaintiff's cross-motion for summary judgment. Plaintiff, Benito Perez, Jr., claims defendant, Aetna Life Insurance Company, has withheld benefits in violation of the Early Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1169. His long-term disability benefits were discontinued on June 30, 1991 by defendant.

FACTS

In November 1984, plaintiff, while working for Motor Wheel Corporation, suffered a severe injury to his heel and ankle when he jumped from a platform to escape an explosion. Plaintiff also had limited education at the time: he never obtained a high school diploma. However, plaintiff obtained a General Education Degree (GED) while he was in the military. Plaintiff had worked for Motor Wheel for sixteen years prior to the injury.

Pursuant to the Disability Insurance Plan in effect at the time between Motor Wheel and defendant, plaintiff was determined to be totally disabled and was granted disability benefits beginning in December 1985. It was determined that plaintiff was a feasible candidate for retraining at the Community College level, and, in 1987, plaintiff entered a program leading to an associate's degree in business management from Lansing Community College. He ultimately obtained his degree in March 1991. Disability benefits continued throughout this period of schooling. On April 8, 1991, defendant notified plaintiff that his benefits would be extended for a period of job placement, as recommended by the rehabilitation counsellor, not to extend past June 30, 1991

Plaintiff enrolled in a computer training course on June 24, 1991 that was scheduled to last twelve weeks. An Amended Vocational Rehabilitation Plan stated that the purpose was to enhance plaintiff's marketability in the business field and to prepare him to handle the duties of a customer service representative.

In response to plaintiff's requests for extension of long-term disability benefits, defendant wrote plaintiff on February 26, 1992 indicating that although the proposed computer training may be valuable, the education and skills obtained in earning the associate's degree sufficiently prepared him to pursue some reasonable occupations, and, therefore, he was no longer "disabled" as defined in the insurance policy. The policy defines "total disability" as meaning "during the twelve month qualifying period, and thereafter during any one period of disability, that the employee is unable, solely because of . . . accidental bodily injury . . . to work at any reasonable occupation." "Reasonable occupation," in turn, is defined as "any gainful activity for which the employee is, or may reasonably become fitted by education, training or experience and in which other people of similar background are actually employed as their principal means of support."

Defendant's determination of non-disability was also based in part on the findings of Dr. Sam Ho, who undertook an independent evaluation of plaintiff's condition in April 1991. Dr. Ho found that plaintiff was not unable to perform some occupations for which he was suited by his education, training, or experience. Dr. Ho noted that plaintiff's treating physician gave restrictions of no lifting more than 25 pounds and no prolonged periods of ambulation. He also found that plaintiff could work within these restrictions and that plaintiff could perform sedentary occupations not requiring prolonged ambulation.

The parties appear to agree that the issue at the center of the dispute is whether defendant was correct in its determination that even though plaintiff's medical condition

did not substantially improve, his disability status as defined by defendant's policy was altered solely because of the education he obtained.

Standard for Motion to Dismiss

A motion to dismiss under Rule 12(b)(6) tests the sufficiency of the pleading. Davis H. Elliot Co., Inc. v. Caribbean Utils. Co., 513 F.2d 1176, 1182 (6th Cir. 1975). Technically, of course, the 12(b)(6) motion does not attack the merits of the case. It merely challenges the pleader's failure to state a claim properly. 5 C. Wright, A. Miller & M. Kane, Federal Practice and Procedure § 1364, at 340 (Supp. 1990).

In deciding a 12(b)(6) motion, the court must determine whether plaintiff's complaint sets forth sufficient allegations to establish a claim for relief. The court must accept all allegations in the complaint at "face value" and construe them in the light most favorable to plaintiff. Scheuer v. Rhodes, 416 U.S. 232, 236 (1974); Windsor v. The Tennessean, 719 F.2d 155, 158 (6th Cir. 1983); Amersbach v. City of Cleveland, 598 F.2d 1033, 1034-35 (6th Cir. 1979).

The complaint must in essence set forth enough information to outline the elements of a claim or to permit inferences to be drawn that these elements exist. Jenkins v. McKeithan, 869 U.S. 411 (1969); German v. Killeen, 495 F. Supp. 822, 827 (E.D. Mich. 1980). The court cannot dismiss plaintiff's complaint unless "it appears beyond doubt that the plaintiff can prove no set of facts in support of its claim which would entitle it to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957). Conclusory allegations are not acceptable,

however, where no facts are alleged to support the conclusion or where the allegations are contradicted by the facts themselves. Vermillion Foam Prods. Co. v. Gen. Elec. Co., 386 F. Supp. 255 (E.D. Mich. 1974).

Standard for Summary Judgment

In reviewing a motion for summary judgment pursuant to Rule 56, this Court should only consider the narrow questions of whether there are "genuine issues as to any material fact and [whether] the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). On a Rule 56 motion, the Court cannot resolve issues of fact, but is empowered to determine only whether there are issues in dispute to be decided in a trial on the merits. Gutierrez v. Lynch, 826 F.2d 1534, 1536 (6th Cir. 1987); In re Atlas Concrete Pipe, Inc., 668 F.2d 905, 908 (6th Cir. 1982).

The crux of the motion is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Anderson v. Liberty Lobby, Inc, 477 U. S. 242, 251-52 (1986), Booker v. Brown & Wiiliamson Tobacco Co. Inc., 879 F.2d 1304, 1310 (6th Cir. 1989).

A motion for summary judgment requires this Court to view "'inferences to be drawn from the underlying facts . . . in the light most favorable to the party opposing the motion.'" Matsushita Electric Ind. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986) (quoting United States v. Diebold, Inc., 369 U.S. 654, 655 (1962)), quoted in Historic Preservation Guild v. Burnley, 896 F.2d 985, 993 (6th Cir. 1989). On the other hand, the opponent has the burden to

show that a "rational trier of fact [could] find for the non-moving party [or] that there is a 'genuine issue for trial.'" Historic Preservation, 896 F.2d at 993 (quoting Matsushita, 475 U.S. at 587).

As the Sixth Circuit has recognized and consistently emphasized, recent Supreme Court decisions encourage the granting of summary judgments where there are no material facts in dispute. Historic Preservation, 896 F.2d at 993 (citing Celotex Corp. v Catrett, 477 U.S. 317 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986)).

The courts have noted that the summary judgment motion may be an "appropriate avenue for the 'just, speedy and inexpensive determination' of a matter." Cloverdale Equipment Co. v. Simon Aerials, Inc., 869 F.2d 934, 937 (6th Cir. 1989) (quoting Celotex 477 U.S. at 327). Consistent with the concern for judicial economy, "the mere existence of a scintilla of evidence in support of the [non-moving party's] positions will be insufficient." Anderson, 477 U.S. at 252. "Mere allegations do not suffice." Cloverdale, 869 F.2d at 937. "[T]he party with the burden of proof at trial is obligated to provide concrete evidence supporting its claims and establishing the existence of a genuine issue of fact." Id

DISCUSSION

A denial of benefits challenged under ERISA ordinarily is to be reviewed under a de novo standard of review. Firestone Tire & Rubber Company v. Bruch, 489 U.S. 101, 115 (1989). However, if the benefit plan itself provides that the administrator is granted discretionary authority to make final decisions on claims for benefits, then

an abuse of discretion standard applies. Anderson v. Graf West Life Assurance Co., 942 F.2d 392 (6th Cir. 1991); Davis v. Kentucky Finance Co. Retirement Plan, 887 F.2d 689, 694 (6th Cir. 1989), cert. denied, 495 U.S. 905 (1990). Defendant also argues that purely factual determinations are reviewed under an abuse of discretion standard, citing Wildbur v. ARCO Chemical Co., 974 F.2d 631 (5th Cir. 1992). Regardless of the standard of review, the parties agree that this Court's review is limited to a determination of the "proper interpretation of the plan and whether an employee is entitled to benefits under it" using only the evidence that was submitted to the plan administrator. Perry v. Simplicity Engineering, 900 F.2d 963, 966 (6th Cir. 1990).

The parties dispute whether an abuse of discretion standard or a de novo standard should be applied in reviewing the denial of benefits. Both parties also contend that regardless of the standard of review, they should prevail as a matter of law. Because I find that even under a de novo review defendant's determination was correct that plaintiff was not disabled as defined in the policy, I need not reach the standard of review issue.

In the summer of 1986, plaintiff was evaluated by Peckham Vocational Industries and found to have strengths in mechanical aptitude, reading level, and problem solving skills, but limitations regarding standing for extended periods and fine finger dexterity. In August 1988, Susan O'Malley of Mid-Michigan Rehabilitation Associates, wrote defendant and estimated that plaintiff would complete his associate's degree either at the end of the Spring or Summer Term of 1989. Ms. O'Malley stated that job placement assistance would be provided to plaintiff until he obtained employment. Also, Dr.

Ho, in 1991, had determined that plaintiff could perform jobs that did not require significant walking or lifting. Finally, in May 1991, defendant completed the associate's degree in business management program at Lansing Community College.

I agree with defendant's conclusion that it was probable that graduates from Lansing Community College's program or other similar programs are employed in jobs for which excessive lifting and walking are not required. Plaintiff did not provide any evidence to the contrary. Plaintiff had the ability and skills to perform jobs that were being performed by other people with similar skills and education. Accordingly, defendant was correct in finding that plaintiff was not disabled as defined by the policy.

Plaintiff appears to argue that he had to be able to "find employment," or that he had to be "competitively, employable, as mentioned in a draft letter that plaintiff cites which was apparently written by Ms. O'Malley. These statements concern the fact that plaintiff would likely benefit from computer training, making him even more employable. However, nothing in the disability policy requires that plaintiff be competitively employable or be actually able to find a job. Therefore, even if computer training was necessary for plaintiff to obtain a job in the actual competitive environment, this would not constitute a "disability" triggering benefits under the policy. As noted above, he need only be shown to be able to perform jobs that other people with similar education, training, and experience are performing.

Defendant correctly found that plaintiff was not disabled as of mid-1991. It is even more clear that had an abuse of discretion standard been used, there was clearly sufficient evidence upon which to base the finding of non-disability. Furthermore, the fact that plaintiff was provided with benefits for three months after he obtained his associate's degree undermines any suggestion that defendant was acting in bad faith. Also, the fact that plaintiff took over four years to complete the two-year program at Lansing Community College support finds that the defendant was acting in good faith. For the foregoing reasons, summary judgment is granted in favor of defendant on the ERISA claim.

Breach of Contract Claim

ERISA preempts state law-based claims relating to employee benefit plans such as for common law breach of contract claims, because claims for benefits under a plan are specifically permitted in 29 U.S.C. § 1132, which provides the exclusive remedy. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) see also, 29 U.S.C. § 114. Consequently, plaintiff's common law breach of contract claim must be dismissed as being preempted by ERISA.

DATED in Kalamazoo, MI
Dec. 7, 1994

/s/_____
RICHARD A. ENSLEN
U.S. District Judge

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

[Filed December 7, 1994]

No. 5:94:CV:42

BENITO T. PEREZ, JR.,
Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant.

JUDGMENT

In accordance with the Opinion entered this date;

IT IS HEREBY ORDERED that defendant's motion for dismissal and for summary judgment, filed September 15, 1994 (dkt. # 20), is **GRANTED**;

IT IS FURTHER ORDERED that plaintiff's motion for summary judgment, filed October 19, 1994 (dkt. # 24), is **DENIED**;

IT IS FURTHER ORDERED that **JUDGMENT** is entered **IN FAVOR OF** defendant and **AGAINST** plaintiff on all counts in the complaint.

DATED in Kalamazoo, MI
Dec 7, 1994

/s/_____
RICHARD A. ENSLEN
U.S. District Judge

MAILING RECIPIENT LIST FOR 5:94-cv-00042 (bad)

December 07, 1994

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APPENDIX F

[Filed March 3, 2000]

No. 95-1111

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT
100 EAST FIFTH STREET, ROOM 532
POTTER STEWART U.S. COURTHOUSE
CINCINNATI, OHIO 45202-3988

LEONARD GREEN
CLERK

DIANE KUNTZ
1513) 564-7014

Filed: March 3, 2000

Ronald C. Weston Sr.
Western District of Michigan at Lansing
315 W. Allega.
Lansing, MI 48933

RE: 95-1111
Perez vs. Aetna Life Ins Co
District Court No. 94-00042

The mandate issued in the above-styled case.

Please be advised that the certified record will be sent under separate cover.

Very truly yours,

Leonard Green, Clerk
(Ms.) Diane Kuntz
Case Manager

cc:

Honorable Richard A. Enslen
Mr. Jeffrey V. Stuckey
Mr. Timothy A. O'Rourke

Court of Appeals Mandate - 3/3/00

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

[Filed March 3, 2000]

No: 95-1111

BENITO T. PEREZ, JR.,
Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant-Appellee.

MANDATE

Pursuant to the court's disposition that was filed 2/10/00 the mandate for this case hereby issues today.

A True Copy.

COSTS: **NONE**

Attest:

Filing Fee.....$
Printing.....$

Total .....$

Deputy Clerk

APPENDIX G

AETNA LIFE INSURANCE COMPANY
HARTFORD, CONNECTICUT

(Herein called the Insurance Company)

Group Policy No.: LTD-340000
Policy Delivered In: Ohio
(State or other Jurisdiction)

Policyholder: THE GOODYEAR TIRE & RUBBER COMPANY

Policy Signed: March 5, 1987

To Take Effect: August 1, 1986

This policy is a contract between the Policyholder and the Insurance Company and shall be construed in accordance with the law of the jurisdiction in which it is delivered.

In consideration of the payment by the Policyholder of premiums in the amounts and at the times hereinafter provided, the Insurance Company hereby agrees with the Policyholder, subject to the terms appearing on this and the following pages of this policy (including, if any, the riders, endorsements, and amendments, to this policy which are signed by the Insurance Company), to pay benefits in accordance with the terms of this policy. The obligations and

the rights of all persons under this policy shall be determined in accordance with the terms of this policy.

In witness whereof the Insurance Company has signed this policy at Hartford, Connecticut.

AETNA LIFE INSURANCE COMPANY

/s/_____
William A. Bailey, President

/s/_____
Lewis R. Mervine, Secretary

/s/_____
Kathleen E. He_____, Registrar

Aetna Life Insurance Company Policy

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Article VI MISCELLANEOUS PROVISIONS

COPY OF APPLICATION

Aetna Life Insurance Company Policy

Article I – GENERAL PROVISIONS

Section 1. Definitions

As used in this policy:

(a) The term "date of issue"means the date this policy took effect as shown on Page 1 of this policy.

(b) Commencing January 1, 1987, "policy anniversaries" shall be deemed to occur on said date, and on the same day in each succeeding year.

(c) The term "policy year" means a period commencing with the date of issue of this policy, or a policy anniversary, and terminating immediately prior to the next succeeding policy anniversary.

(d) The first "policy month" shall commence on the date of issue. Each "policy month" thereafter shall be deemed to commence on the first day of the calendar month.

(e) "Contributory insurance" means insurance for which an employee makes written request to his Participant Employer and agrees to make the required contributions to his Participant Employer. "Non-contributory insurance" is insurance for which an employee does not make written request nor contribute toward the cost. This policy provides insurance on the non-contributory basis with respect to the Non-Contributory Benefit provided under Section 2-A(1). of Article II and on the contributory basis with respect

to the Optional Contributory Benefit provided under Section 2-A(2) of Article II.

Section 2. List of Participant Employers

An Employer shall be eligible to be included in this list as a Participant Employer if such inclusion is not contrary to any applicable insurance law of the state or other jurisdiction in which this contract is delivered.

The Policyholder may act for and on behalf of any and all of the Employers included in this list in all matters pertaining to this contract, and every act done by the Policyholder, agreement made between the Insurance Company and the Policyholder, or notice given by the Insurance Company to the Policyholder or by the Policyholder to the Insurance Company, shall be binding on all such Employers.

An eligible Employer may be added to this list as a Participant Employer only upon written agreement between the Policyholder and the Insurance Company and upon terms mutually agreeable to them.

An Employer shall be eliminated automatically from this list when this contract is discontinued with respect to employees of such Employer, as provided for elsewhere in this contract, but termination of an Employer's status as a Participant Employer shall not relieve such Employer from any obligations to the Insurance Company with respect to the time such Employer was a Participant Employer under this contract.

This list shall, at any time, consist of those Employers which have been included under this contract by written agreement between the Policyholder and the Insurance Company, and which have not been removed, in accordance with the above terms of thus section.

Section 3. Employees to be Insured

A. Employees Eligible:

All employees of a Participant Employer shall be eligible for insurance except employees in the following classes:

(1) part-time employees (but not excepting full-time employees temporarily working on a part-time basis or employees hired on a permanent schedule of less than normal hours);

(2) employees classified as temporary by such Employer;

(3) employees in the field not on Home Office payrolls;

(4) employees who are employed outside the area embraced by the United States of America, other than by reason of Temporary Travel abroad from a home office within such area or by reason of being transferred from an employment within such area to a point outside such area;

(5) employees who are represented by collective bargaining representatives;

(6) employees who have attained the age of 69 on the date their insurance would otherwise become effective.

(7) employees who are agricultural laborers employed by Goodyear Farms;

(8) employees who are not eligible for the supplemental unemployment compensation benefits plan for salaried employees of a Participant Employer.

With respect to employees whose Annual Rate of Basic Earnings is $50,000 or more:

Each employee in an eligible class whose employment commenced on or before the date of issue shall become eligible for insurance on the date of issue, and each other employee in an eligible class shall become eligible for insurance on the date he enters the service of a Participant Employer.

With respect to all other employees:

Each employee in an eligible class whose employment commenced on or before the date of issue shall become eligible for insurance on the date of issue, and each other employee in an eligible class shall become eligible for insurance on the date on which he completes one year of continuous service.

Any employee of a Participant Employer who is insured under this group policy and who is subsequently transferred from the payroll of such a Participant Employer to the payroll of a subsidiary or affiliated company of The Goodyear Tire & Rubber Company, that is not listed as a Participant Employer in this group policy, shall continue to be eligible for insurance under this group policy subject to all of its terms.

Anything to the contrary notwithstanding, if an individual is in the employ of or connected with two or more Participant Employers, he shall not be eligible for multiple coverage under this policy, but shall be treated the same as if he were in the employ of or connected with a single Participant Employer, the amount of insurance for which any such individual shall be eligible under this policy shall under no circumstances exceed the amount which would apply if all of the Participant Employers with which he is employed or connected were a single Participant Employer and if the aggregate of this remuneration being paid to him by all such Participant Employers were being paid to him by a single Participant Employer.

If any Participant Employer is a partnership, the natural-person partners thereof shall be considered to be employees within the meaning of this policy if and while they are actively engaged in and devoting at least thirty hours per week to the conduct of the business of the partnership. If any Participant Employer is a sole proprietorship, the natural-person proprietor thereof shall be considered to be an employee within the meaning of this policy on the same terms as those applicable to partners of a partnership.

B. Effective Dates of Insurance:

As to contributory insurance, each employee who makes written request to a Participant Employer for insurance and agrees to make the required contributions therefor to such Participant Employer is to be insured on the date he becomes eligible therefor or on the date he makes such request, whichever is later; provided, however, that

(1) the insurance of any employee who makes such written request after thirty-one days from the date he becomes eligible, or who revokes, any written request previously made, shall become effective only if and when the Insurance Company gives its written consent;

(2) any employee who is both disabled (i.e. ill or injured) and away from work on the date his insurance is to become effective shall not be insured until he actually returns to work for a Participant Employer on a full-time basis.

As to non-contributory insurance, each employee is to be insured on the date he becomes eligible; provided, however, that any employee who is both disabled (i.e., ill or injured) and away from work on the date his insurance is to become effective shall not be insured until he actually returns to work for a Participant Employer on a full-time basis.

Aetna Life Insurance Company Policy

Section 4. Effect Of Coverage Under The Prior Policy

An employee's insurance under this policy replaces and supercedes employee's insurance, if any, under the Insurance Company's Group Policy No. LTD- 338096 (hereinafter referred to as the prior policy) and shall be in exchange for all privileges and benefits under the prior policy. However, if an employee becomes entitled to claim under the prior policy, his insurance under this policy shall be cancelled, as of its effective date, and any premiums paid for his insurance under this policy shall be refunded to the Policyholder.

Article II--LONG TERM DISABILITY BENEFITS

Section 1. Definition

As used in this Article:

(a) "Physician" means a legally qualified physician.

(b) "Monthly rate of basic earnings" means as to any period of total disability:

(i) With respect to any employee other than an employee specified in (ii) below, the employee's monthly rate of earnings in effect for the last complete payroll period immediately preceding the commencement of the period of total disability, exclusive of night bonuses, overtime pay, suggestion

awards, prizes and other compensation as determined by the Participant Employer, from time to time without discrimination. Monthly earnings will include an appropriate adjustment for items of compensation which are variable or paid other than monthly;

(ii) With respect to an employee who is paid on a guaranteed salary plus commission basis; the sum of items (ii-a) and (ii-b) below:

(ii-a) the average monthly rate of earnings in effect for the last 12 months immediately preceding the commencement of the period of total disability;

(ii-b) the average monthly commission for the last 12 months immediately preceding the commencement of the period of total disability.

In no event will the monthly rate of basic earnings exceed $7,500.

A retroactive change in an employee's rate of earnings shall be deemed to be effective on the date of the determination of the change in the rate of earnings.

(c) "Approved employment" means a period of full-time work for the Policyholder in an occupation other than the employee's occupation at the Policyholder at the commencement of the period of total disability, or a period of full-time work for an employer other than the Policyholder at an occupation which is not a substantially gainful occupation or a period of part-time work for any employer, which the Insurance Company approves in writing, and which shall be considered to begin only when the Insurance Company gives its approval thereto and to end when the Insurance Company withdraws such approval.

(d) While an approved employment provision is applicable to an employee, "monthly rate of basic earnings", in respect of any month, means the excess, if any, of item (i) below or over item (ii) below:

(i) the amount of monthly benefit payable to the disabled employee determined on the basis of the terms of this policy exclusive of this item (d);

(ii) 100% of the employee's pre-disability monthly rate of basic earnings less any disability or retirement benefits payable by Social Security including any benefits payable to his dependents on account of the employee's disability,

the earnings the employee receives from his Approved Employment, any benefits payable to an employee by the Policyholder because he is ineligible to receive benefits under the Federal Social Security Act and any other income benefits.

(e) "Qualifying period" means, as to any one period of total disability of an employee, the first 12 months of such period of total disability. Only one qualifying period is required with respect to those periods of total disability which are considered as one period of total disability under Section 2 of this Article II.

(f) "Reasonable occupation" means any gainful activity for which the employee is, or may reasonably become, fitted by education, training, or experience, and in which other people of similar background are actually employed as their principal means of support.

(g) "Total disability" or "totally disabled" means, during the twelve month qualifying period and thereafter during any one period of disability, that the employee is unable, solely because of disease, accidental bodily injury or a pregnancy-related condition to work at any reasonable occupation.

Section 2. Income

A. If a period of total disability of an employee commences while the employee is insured hereunder and continues during and beyond the qualifying period, proof of loss is furnished in accordance with Article VI, the Insurance Company shall, subject to the terms of this policy, pay a monthly benefit during the continuance of the period of total disability while the employee is "totally disabled" as defined in Section 1 of this Article II, commencing with the first day following the completion of the qualifying period.

(1) Non-Contributory Benefit

The amount of monthly benefit payable under this policy for a given monthly period of total disability shall be 60% of the employee's monthly rate of basic earnings if no other income benefits are payable for the given monthly period.

If other income benefits are payable for a given monthly period, the amount of monthly benefit payable under this policy for the given monthly period shall be an amount equal to the excess, if any, of (i) 60% of the employee's monthly rate of basic earnings over (ii) the amount of other income benefits payable for the given monthly period.

(2) Optional Contributory Benefit - Subject to the requirements relating to the effecting of contributory insurance, the amount of monthly benefit payable

under this item (2) shall be 10% of the employee's monthly rate of basic earnings.

B. A "period of total disability" of an employee shall be deemed to commence on the later to occur of

(1) the first day that the employee is totally disabled, and

(2) the thirty-first day immediately preceding the date the employee, was during the period of total disability, first seen and treated personally by a physician in connection with the disease, injury or pregnancy-related condition which caused such disability;

and the period of total disability shall be deemed to terminate, unless otherwise specifically provided for in this Article II, on the earliest to occur of

(a) the date the employee is no longer "totally disabled" as defined in Section 1. of this Article II;

(b) the date upon which the employee commences work at any occupation, either with a Participant Employer or any employer, including self-employment;

(c) the date the employee fails to furnish proof of the continuance of total disability, or refuses to be examined, when required in accordance with Article VI;

(d) the date the employee ceases to be under the care of a physician;

(e) as to a period of total disability which commences prior to the date he attains the age of sixty-four years, the earlier to occur of (i) the date the employee retires and (ii) the date such employee attains the age of sixty-five years;

(f) as to a period of total disability which commences on or after the date he attains the age of sixty-four years but prior to attainment of age 69, the earlier to occur of (i) the expiration of twelve months of total disability following the completion of the qualifying period, (ii) the date the employee attains the age of seventy years and (iii) the date the employee retires;

(g) the date of the employee's death.

C. Any two separate periods of total disability which arise from the same or related causes and which are separated by less than 6 months shall be considered as one period of total disability, except that the earlier of such separate periods shall not be taken into account if at the beginning of such earlier period the employee was not insured under this policy. Having combined two separate periods into a single period, this rule may be applied successively to any further separate period of total disability, provided such further separate period of total disability also arises from the

same or related causes and is not separated from the last preceding such period by more than 6 months.

D. Other income benefits, referred to above, shall include the following:

(1) Income received from any approved employment.

(2) 50% of any award provided under the Jones Act or the Maritime Doctrine of Maintenance, Wages and Cure.

(3) Disability or retirement benefits required or provided for under any law of a government – for example.

(a) temporary or permanent, partial or total, disability benefits under any workers' compensation law or any other similar law, which are intended to compensate the worker for any one or more of the following

(i) loss of past and future wages,

(ii) impairment of earning capacity or diminished ability to compete in the open labor market, and

(iii) any degree of permanent impairment or loss of bodily function or capacity,

(b) any company providing disability benefits,

(c) statutory disability benefits,

(d) benefits under the Federal Social Security Act, the Canada Pension Plan, and the Quebec Pension Plan.

Benefits payable to the employee or to his spouse, children, and dependents by reason of the employee's disability or retirement shall be included as other income benefits.

For the purposes of determining other income benefits:

(1) Any single sum payment made in settlement of a claim for workers' compensation benefits

(a) will be considered, to include disability benefits of 50% of the total gross amount of such single sum payment is or is not the result of a compromise, award or judgment, unless there exists in the terms of the compromise, award or judgment (or in the record of the proceeding resulting in such payment) evidence satisfactory to the Insurance Company that a greater or lesser percentage should be applied; and

(b) the amount so determined will be allocated by the Insurance Company, in equal amounts, to a sixty month period which shall commence (i) on the same date as the period with respect to which the single sum payment is made, or (ii) on the date on which the single sum payment is made if the compromise, award, or judgment does not allocate the single sum payment to any specific period.

(2) Any other single sum payment (including any periodic payments which the individual could have elected to receive in any single sum) shall also be allocated in its entirety by the Insurance Company, in equal amounts, to sixty monthly periods, and may also be allocated retroactively by the Insurance Company if received pursuant to a retroactive award.

(3) The Insurance Company shall have the right to allocate any other periodic payments or an amount which represents an accumulation of past due periodic payments to monthly periods and to make such allocation when such payments are received pursuant to a retroactive award.

Section 3. *Exclusions, Limitations, and Other Provisions Relating to Long Term Disability Benefits.*

No insurance is afforded under this policy

(a) as to a disability due to intentionally self-inflicted injuries (whether sane or insane); or

(b) as to a disability resulting from the commission by the employee of, or an attempt by the employee to commit, an assault, battery, or felony; or

(c) as to a disability due to war or any act of war (whether war is declared or not); or

(d) as to a disability due to insurrection, rebellion, or participation in a riot or civil commotion; or

Section 4. Extension of Benefits

If an employee's insurance terminates during a period of total disability which commenced while such insurance was in force, any benefits otherwise provided under this policy shall continue to be available during the continuance of such period

Section 2. Income Benefits

E. Special provision regarding increases in governmental benefits:

An increase in the level of one or more governmental benefits payable which becomes effective during a period of total disability of the employee and after the effective date of this provision will not be considered other income benefits, other than to the extent that the increase is due to a change in the number of the employee's family members, or to any recomputation or recalculation for the purpose of correcting or adjusting the employee's benefit level as originally

established with respect to file particular period of disability.

Article III--TERMINATION OF INSURANCE

The insurance of any employee under this policy shall terminate at the earliest time specified below:

(a) Upon discontinuance of the policy.

(b) Immediately when the employee's employment with a Participant Employer in the classes of employees eligible for insurance terminates. Cessation of active work by an employee shall be deemed to be termination of his employment, except that

(i) in the case of an absence from active work because of sickness or injury, his employment may, for the purposes of insurance under this policy, be deemed to continue until terminated by his Participant Employer, or

(ii) in the case of absence from active work because of temporary lay-off, his employment shall, for the purposes of insurance under this policy, be deemed to terminate on the employee's last full day of active work prior to the commencement of the lay-off, or

(iii) in the case of absence from active work because of an authorized leave of absence, his employment shall, for the purposes of insurance under this policy, be deemed to

terminate 90 days following the commencement of such leave of absence.

In the case of any continuation of insurance in accordance with the foregoing item (i), or (iii) the insurance under this policy for such employee shall automatically cease on the date of such termination of his employment by his Participant Employer, as evidenced to the Insurance Company by the Policyholder, whether by notification or by cessation of premium payment on account of such employee's insurance hereunder.

(c) The end of the calendar month in which the employee attains the age of 69 years.

In no event may any insurance provided on a contributory basis be continued beyond the end of the period for which the employee has made to his Participant Employer the contributions required.

Reinstatement – With respect to an employee whose insurance was terminated due to a layoff, if said employee returns to active work and receives credit for prior service, the insurance for said employee will be reinstated for non-contributory coverage on the date of such re-employment, and for contributory coverage on the date said employee both (l) makes written request to a Participant Employer for insurance and (2) agrees to make required contributions therefor.

Article IV – PREMIUMS

Section 2. Experience Rating

The premium rates specified above shall be subject to such reductions or increases as the Insurance Company shall determine to be warranted by experience or by reason of any change in factors bearing on the risk assumed. Each reduction or increase in any premium rate shall be made by written notification to the Policyholder by the Insurance Company.

No premium rate may be increased except either by written notification from the Insurance Company to the Policyholder before the effective date of such increase or by mutual agreement between the Policyholder and the insurance Company.

No experience reduction or increase in premium rates shall become effective less than twelve months after the effective date of this policy.

If at any time the aggregate of employee contributions theretofore made for group insurance shall exceed the aggregate of premiums theretofore paid for group insurance, such excess shall be applied by the Policyholder for the sole benefit of employees, but the Insurance Company shall not be obliged to see to the application of any such excess.

Aetna Life Insurance Company Policy

Section 3. Premiums, How Payable

Premiums shall be payable by the Policyholder in advance at the Home Office of the Insurance Company or to its authorized agent.

The first premium under this policy shall be due and payable as of the date of issue to cover the period beginning on that date and ending on the last day of the first policy month and thereafter premiums shall be due and payable on the first day of each policy month.

Premium payments shall not be required for an employee's insurance on any premium due date during a period for which the employee is entitled to receive benefits under this policy.

Section 4. Grace Period

A grace period of 31 days following the due-date shall be allowed the Policyholder for the payment of each premium.

Section 1. Premium Calculations and Premium Rates (Continued)

Monthly Rates Per $100 of Monthly Benefit

Age Nearest Birthday	Rate
Under 40	$ .35
40 or over but less than 45	.78
45 or over but less than 50	1.54
50 or over but less than 55	2.74
55 or over but less than 60	2.35

60 or over but less than 64	1.72
65 or over	2.03

Article IV--PREMIUMS

Section 1. Premium Calculations and Premium Rates

The premium shall be determined by multiplying one-hundredth of the amount of monthly benefit in force by the average rate per $100 of monthly benefit as determined below.

The average rate per $100 of monthly benefit shall be determined as of the date of issue by dividing the total of the individual premiums required, according to the table of monthly rates per $100 of monthly benefit at the ages (nearest birthday) of the employees insured as of the date of issue and for the respective amounts of monthly benefit then in force on their lives, by one-hundredth of the approximate amount of such monthly benefits.

The same average rate will be continued thereafter, provided that a recalculation of such average rate in the same manner may be required, as of any premium-due date, (a) by the Insurance Company, when warranted by a change in factors bearing on the risk assumed, or (b) by the Policyholder, subject to sixty days advance notice to the Insurance Company. Such recalculation shall be made upon the basis of the then attained ages, the amounts of monthly benefit in force, and the scale of monthly rates in effect, all taken as of the date of the recalculation. Such recalculated rate shall thereafter constitute the average rate to be used in determining

the premiums payable hereunder, subject, however, to further recalculations under the same conditions.

The amount of monthly benefit, as used in this Article, shall mean the amount determined from Article II.

Any insurance becoming effective shall be charged for from the first day of the policy month coinciding with or next following the date the insurance takes effect. Premium charges for any insurance terminated shall cease as of the first day of the policy month coinciding with or next following the date the insurance terminates. If premiums are payable quarterly, semi-annually, or annually, premium charges or credits for a fraction of a premium-paying period shall be made on a pro-rata basis for the number of policy months between the date premium charges commence or cease and the end of the premium-paying period.

Instead of the method of calculation of premiums above provided, premiums may be calculated by any method which produces approximately the same total amount of premiums and is mutually agreeable to the Policyholder and the Insurance Company.

The Premium Rates shall be determined from the table on the following page.

Article V. DISCONTINUANCE OF POLICY

The Policyholder may discontinue this policy with respect to all or any class of employees of any one or more Participant Employers, and any Participant Employers, and any

Participant Employer may discontinue this policy with respect to all or any class of employees of such Employer, by giving to the Insurance Company written notice stating when, after the date of such notice such discontinuance shall become effective; but no such discontinuance shall become effective with respect to employees of any Participant Employer during any period for which a premium has been paid to the Insurance Company with respect to such employees of the Employer.

The Insurance Company reserves the right to discontinue this policy,

(a) with respect to all or any class of employees of any Participant Employer, at any time on or after the end of the grace period allowed for payment of a premium with respect to such employees of the Employer which has not been paid, by giving written notice to the Policyholder stating such discontinuance shall become effective;

(b) either in its entirety or with respect to all or any class of employees of any Participant Employer, at any time, by giving to the Policyholder written notice stating the date as of which such discontinuance shall become effective, but such date shall not be one that occurs earlier than thirty-one days after the date of such notice unless mutually satisfactory to the Policyholder and the Insurance Company.

If this policy discontinues with respect to any of the employees of a Participant Employer, the Policyholder and the Employer shall be jointly and severally liable to the Insurance Company for all unpaid premiums for the period during which this policy was in force with respect to any of the employees of such Employer.

Article VI - MISCELLANEOUS PROVISIONS

Section 1. Assignment

No assignment of any present or future right, interest, or benefit under this policy shall bind the Insurance Company without its written consent.

Section 2. Employees' Certificates

The Insurance Company will issue to the Policyholder, for delivery to each insured employee, an individual certificate setting forth a summary of the essential features of the insurance coverage to which the employee is entitled and stating to whom the benefits are payable.

Section 3. Data Required - Clerical Error - Misstatements - Non- Discrimination

The Policyholder and each of the Participant Employers shall furnish to the Insurance Company all information which the Insurance Company may reasonably require with regard to any matters pertaining to this policy. All documents, books, and records which may have a bearing on the insurance premiums shall be open for inspection by the Insurance Company at all reasonable times during the continuance of

this policy and until the final determination of all rights and obligations, under this policy.

Neither clerical error (whether by the Policyholder, by any of the Participant Employers, or by the Insurance Company) in keeping any records pertaining to the insurance, nor delays in making entries thereon, shall invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment of premiums shall be made.

If any relevant facts pertaining to any individual to whom the insurance relates shall be found to have been misstated, an equitable adjustment of premiums shall be made, and if such misstatement affects the existence or the amount of insurance, the true facts shall be used in determining whether insurance is in force under the terms of this policy and in what amount.

No refund of any premium or portion thereof, whether paid in error or otherwise, shall be made for any period commencing earlier than (a) three months prior to the date on which evidence that the particular refund should be made is received by the Insurance Company, or (b) the beginning of the policy year in which such evidence is received, whichever method (a) or (b) above would result in the greater refund.

In connection with the administration of this policy, the Policyholder and the Participant Employers shall act so as not to discriminate unfairly between individuals in similar situations at the time of such action, but the Insurance Company shall be entitled to rely upon any action of the Policyholder or of any of the Participant Employers without being obliged to inquire into the circumstances thereof.

Aetna Life Insurance Company Policy

Section 4. Entire Contract: Changes

This policy constitutes the entire contract between the parties, and any statement made by the Policyholder or by any employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this policy or be used in defense in a claim unless it is in writing, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used to void this policy after it has been in force for two years from the date of its issue, nor shall any such statement of any employee eligible for coverage under the policy, except a fraudulent misstatement, be used in defense to a claim for loss incurred or commencing after the insurance coverage with respect to which claim is made has been in effect for two years.

This policy is issued in the non-participating department of the Insurance Company. This policy may be changed at any time or times by written agreement between the Insurance Company and the Policyholder, without the consent of any employee or other person. No change in this policy shall be valid unless approved by an executive officer of the Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions

Failure to insist upon compliance with any provision of this policy at any given time or times or under any given set or sets of circumstances shall not operate to waive or modify such provision, or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other

occurrence or occurrences, whether the circumstances are, or are not, the same.

Section 5. Time Limit on Certain Defenses

No claim for disability commencing after one year from the effective date of the insurance coverage with respect to which claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which claim is made.

Section 6. Proofs of Loss

Written proof of total disability must be furnished to the Insurance Company within ninety days after the expiration of the qualifying period. Subsequent written proof of the continuance of such disability must be furnished to the Insurance Company at such intervals as the Insurance Company may reasonably require. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required. No action at law or in equity shall be brought to recover on this policy after the expiration of three years after the time written proof of loss is required to be furnished.

The Insurance Company shall have the right to require as part of the proof of claim satisfactory evidence (1) that the

employee, spouse, child, or dependent has made application (and has, within a reasonable length of time following denial of such benefits, made reapplication) for all benefits referred to in Section 2 of Article II, (2) that he has furnished all required proofs for such benefits, (3) that he has not subsequently waived such benefits, and (4) of the amount of all such benefits payable. The employee need not make application for (a) retirement benefits available only on a reduced basis or (b) disability benefits under a group life insurance policy if the payment of such benefits would reduce the amount of life insurance under such policy; such benefits shall however, be considered as other income benefits if applied for and received.

The Insurance Company, at its own expense, shall have the right and opportunity to have a physician it designates examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the period for which such individual claims benefits under this policy.

Section 7. Payment of Claim

Subject to proof of claim, all accrued benefits under this policy shall, except as otherwise specifically provided, be paid at the end of each calendar month during the period for which benefits are payable, hereunder. The Insurance Company may, however, make such payments on a quarterly, semi-annual, or annual basis in the event that a monthly payment would be less than $10.00. Any balance remaining unpaid at the termination of such period shall be paid immediately upon receipt of due proof. Benefits are payable to the insured employee.

A benefit payable for a period which is less than a full month shall be prorated on the basis of the ratio of days of eligibility during such month to thirty days.

If any benefit under Article II of this policy shall be payable to the estate of the insured employee, or to an insured employee who is a minor otherwise not competent to give a valid release, the Insurance Company may pay such benefit up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured employee who is deemed by the Insurance Company to be equitably entitled thereto. Any payment made by the Insurance Company in good faith pursuant to this provision shall fully discharge the Insurance Company to the extent of such payment.

Section 8. Recovery of Benefits

In the event that an employee receives a monthly benefit payment under this policy which is in excess of the monthly benefit payment which should have been made, the Insurance Company shall have the right to recover the amount of such excess from the employee. The Insurance Company may, however, at its option, deduct the amount of such excess from any subsequent monthly benefits payable to the employee.

Section 9. Determination by the Policyholder

Subject to adjustment for error, the determination and findings made in good faith by the Policyholder with respect to (1) the fact and time of commencement, duration and termination of an employee's employment, lay-off, leave of absence, or other absence from work, (2) the monthly rate of basic earnings of any employee, and (3) any fact relating to any

retirement plan of a Participant Employer, shall be conclusive and binding upon all persons for the purposes of this policy.

Supreme Court, U.S.
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No. 99-1836

IN THE

Supreme Court of the United States

BENITO T. PEREZ,

Petitioner,

v.

AETNA LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

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STATEMENT PURSUANT TO RULE 29.6

Respondent, Aetna Life Insurance Company, is a wholly-owned subsidiary of Aetna Inc., which is publicly traded.

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STATEMENT OF THE CASE

Sitting in *en banc* review of an earlier panel decision, the United States Court of Appeals for the Sixth Circuit held in its July 1, 1998 opinion that the specific language of an ERISA plan giving Respondent Aetna Life Insurance Company "the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for such benefits . . . ," gave Aetna discretion to determine whether claimants are entitled to benefits under the plan. Petitioner Benito T. Perez claims that a writ of certiorari is warranted to resolve a split between the Sixth Circuit and the United States Courts of Appeals for the Second and Ninth Circuits which held that similar plan language did not vest discretion.

A. Plaintiff's Claims and Their Disposition In The District Court.

Petitioner worked for 16 years for Motor Wheel Corporation, a division of Goodyear Tire and Rubber Company, in Lansing, Michigan (Appendix B at 10a). He fractured his left heel and ankle on the job in 1984 (Appendix E at 78a). As of December 1, 1985, Aetna determined that he was "totally disabled" under the ERISA-governed plan at issue, which defined "total disability" as being "unable, solely because of . . . accidental bodily injury . . . to work at any reasonable occupation" (Appendix B at 11a). "Reasonable occupation" is defined as "any gainful activity for which the employee is, or may reasonably become, fitted by education, training, or experience, and in which other people of similar background are actually employed as their principal means of support" (*Id.*).

In 1987, Petitioner, who had a General Education Development (GED) diploma, enrolled in Lansing Community College to get an associate's degree in business management, which he received in 1991. From 1985 through 1991, Aetna paid Petitioner benefits (Appendix B at 11a-12a).

Aetna informed Petitioner that benefits would end as of June 30, 1991, given the completion of his degree. In June 1991, Petitioner enrolled in a 12 week computer training course and requested that Aetna extend the disability benefits until he completed that training as well. Aetna declined his request, informing him that he had "acquired sufficient education and skills by virtue of [his] obtaining [his] Associate of Arts Degree in Business Management and [was] now able to pursue some reasonable occupation." Aetna paid no benefits after June, 1991 (Appendix B at 12a).

While receiving benefits from Aetna, Petitioner also received workers' disability compensation from the State of Michigan until December 5, 1992, when he became employed as a laboratory technician at the Laboratory of Clinical Medicine at Michigan State University (Appendix B at 14a). Petitioner quit after only one week and applied for reinstatement of his workers' compensation benefits. A workers' compensation magistrate denied his request in an administrative hearing, finding that Petitioner was able to perform — and did perform — the occupation of a laboratory technician (*Id.*).

Petitioner sued Aetna under 29 U.S.C. § 1132(a)(1)(B) to recover benefits (Appendix B at 15a). On cross-motions for summary judgment, Aetna argued that its decision was governed by the arbitrary and capricious standard of review because the plan states that "[Aetna] shall have the right to

require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for such benefits . . . ." Aetna also argued that the Michigan workers' compensation administrative determination that Petitioner was able to engage in a reasonable occupation was collateral estoppel that precluded Petitioner from claiming that no reasonable occupation existed for which he was qualified.

The district court granted summary judgment for Aetna after determining that the standard of review did not matter, because even under a *de novo* standard Aetna's decision was correct (Appendix E at 83a).

B. Disposition By The Panel And *En Banc* Court on Appeal.

The original panel of the United States Court of Appeals for the Sixth Circuit reversed the district court's holding upon finding that the standard of review was dispositive, because in its view under a *de novo* standard of review Aetna's decision was not correct (Appendix D at 52a). The panel held in its September 23, 1996 opinion that the plan language did not explicitly say that the evidence of disability had to be satisfactory **to Aetna**, and therefore it did not clearly vest discretion in Aetna to make that determination (Appendix D at 65a-67a).

The Court of Appeals for the Sixth Circuit granted Aetna's petition for *en banc* review on the ground that the panel's September 23, 1996 opinion was in direct conflict with an earlier published Sixth Circuit opinion, *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376 (6th Cir. 1996), which the panel in this case did not cite or acknowledge

(Appendix B at 10a). *Yeager* held that a plan vests discretion when it requires a claimant to submit "satisfactory evidence" of disability, regardless of whether it expressly says that the evidence must be satisfactory to the decision-maker.

The *en banc* Sixth Circuit court held in this case that the particular plan language at issue did vest discretion.[1] Noting that this Court has never suggested that " 'discretionary authority' hinges on incantation of the word 'discretion' or any other 'magic' word," courts under *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), must "focus on the breadth of the administrator's power — their 'authority to determine eligibility for benefits or to construe the terms of the plan'." *Perez*, 150 F.3d at 555 (quoting *Firestone*, 489 U.S. at 115, 109 S. Ct. 948) (Appendix B at 18a). The *en banc* court thus correctly held that plan language which requires a claimant to submit "satisfactory proof" of disability gives discretion to the administrative decision-maker even if it does not specify that it must be satisfactory **to the decision-maker**, since the decision-maker to whom it is submitted is the only entity that could possibly make that determination (Appendix B at 17a-25a).

The *en banc* court remanded the case to the original panel with instructions to dispose of the appeal using the arbitrary and capricious standard (Appendix B at 25a). On February 10, 2000, the original panel affirmed the district court's determination that Aetna's decision was not arbitrary or capricious (Appendix A at 2a).

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1. Like the original panel, the *en banc* court did not reach the collateral estoppel issue Aetna raised (Appendix B at 16a-17a).

REASONS FOR DENYING THE WRIT

I.

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED ON THE MERITS.

A. The Sixth Circuit's Decision Does Not Conflict With *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989).

The courts of appeals have consistently stated that *Firestone Tire & Rubber Co. v. Bruch*, 498 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), "did not suggest that 'discretionary authority' hinges on incantation of the word 'discretion' or any other 'magic word'." *Johnson v. Eaton Corp.*, 970 F.2d 1569, 1572 n.2 (6th Cir. 1992) (quoting *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1453 (D.C. Cir. 1992)). Instead, *Firestone* requires a court to "focus on the breadth of the administrator's power — their 'authority to determine eligibility for benefits or to construe the terms of the plan'." *Block, supra*, 952 F.2d at 1453 (quoting *Firestone*, 489 U.S. at 115, 109 S. Ct. at 948).

There is absolutely no inconsistency between the Sixth Circuit's decision in the present Petition and this Court's decision in *Firestone*. Indeed, *Firestone* **requires** that the administrator's "authority to determine eligibility for benefits" be the benchmark for deciding whether a plan vests discretion, not whether particular words are used. The Sixth Circuit held that Aetna had such authority in this case because the plan provided that eligibility for benefits would depend upon the claimant providing satisfactory evidence of disability. That holding is in perfect harmony with *Firestone*.

This Court in *Firestone* already has resolved the only issue of general importance in the field. In that case, this Court decided that under ERISA, the deferential "arbitrary and capricious" standard of review applies when the administrator of an insurance plan has "discretion" under a plan to interpret its terms or to apply them to specific insurance claims. Otherwise, the courts may review the decision *de novo*. This Court appropriately left it to the lower courts to determine whether particular plans authorize the exercise of discretion about specific types of decisions.

The "conflict" petitioner urges in this case does not relate to any general principle of law. Rather, it involves merely the application of *Firestone* to the language of specific insurance contracts. These decisions are, therefore, inherently fact bound and involve the type of issue that this Court "rarely" reviews. *See* Sup. Ct. R. 10 (noting that a petition for certiorari "is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law"). There is no compelling reason for this Court to determine how much discretion particular phrases in particular companies' insurance contracts give to plan administrators in addressing particular types of claims.

Moreover, to the extent that some circuits may require clearer language about the existence and scope of the plan administrator's discretion, this issue can and should be resolved through changes in the text of insurance contracts. It is hardly necessary for this Court to intervene to superintend the details of contract drafting.

B. The Supreme Court Has Previously Denied Certiorari On The Identical Issue.

This Court has previously denied review of the identical issue Petitioner now raises. On November 1, 1999, this Court unanimously denied a writ of certiorari to the Court of Appeals for the Ninth Circuit in *Standard Insur. Co. v. Kearney*, 120 S. Ct. 389, 145 L. Ed. 2d 310, 68 U.S.L.W. 3289 (1999). The Ninth Circuit held, *en banc*, that plan language requiring "satisfactory written proof" of disability did not vest discretion. *Kearney*, 175 F.3d at 1089-90. In doing so, it expressly disagreed with the Sixth Circuit's *en banc* decision in *Perez*, *id.* at 1089, which is the subject of the present Petition.

This Court denied certiorari in *Kearney*, which was argued to be in conflict with *Perez*, which is the subject of the present Petition. The present Petition is the mirror-image, and presents the same issue of which this Court denied review in *Kearney*. Having previously determined that the issue did not warrant review, the Court should similarly deny review in this case.

C. The Sixth Circuit's Decision Does Not Conflict With Any Other Decision Of Another Court Of Appeals On The Same Important Matter.

The present case, and those decisions which Petitioner argues are in conflict with it, do not involve an "important matter" worthy of review. The decisions deal with the narrow and specific terms of particular ERISA plans and policies, and do not involve any broad principle of law. They instead focus on the narrow question of whether the particular phrase "satisfactory evidence" or "satisfactory proof" vests

discretion. Resolution of that question by this Court would have absolutely no application beyond those particular plan terms, and resolving it does not entail any broad or important legal issues under ERISA.

In attempting to broaden the significance of the issue raised in this case, Petitioner asserts that "[n]o policy authorized by any insurer would state that benefits will be paid upon the receipt 'of evidence'," and that "[e]very policy includes some qualifier suggesting a quantum or quality of the evidence required" (Petition at 10-11). That bald, unsupported assertion is demonstrably false. Insurance policies and welfare benefit plans often lack qualifiers regarding the quantum or quality of evidence. Numerous courts have considered, and found wanting, plan language that does not contain such qualifying statements of the kind of proof a claimant must provide in making a claim for benefits. *See, e.g.*, *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309 (D. Mass. 1996) (no discretion where plan simply said claimant must submit proof of loss for benefits); *Starita v. Nycare Health Plans, Inc.*, 2000 U.S. Dist. LEXIS 3898 *6 (E.D. Pa. March 29, 2000) (plan provided benefits "[w]hen proof is received by the Insurance Company that an insured employee is totally disabled"); *Hensley v. Fortis Benefits Ins. Co.*, 1999 U.S. Dist. LEXIS 17270 *14 (W.D. Mich., Aug. 24, 1999) ("the language in this case does not use the word 'satisfactory' or a similar word," but rather "the language in the [p]olicy speaks in terms of the claimant's duty to furnish evidence"); *McBride v. Continental Cas. Co.*, 1999 U.S. Dist. LEXIS 6782 *12 (E.D. Pa. May 11, 1999) ("[t]here is no requirement of 'satisfactory proof,' 'due proof' or anything similar in the section explaining what information a claimant must submit").

Second, Petitioner greatly overstates the significance of the Sixth Circuit's *en banc* decision, proclaiming that "[t]he decision affects the manner of review of millions of plans, policies, and benefit programs" (Petition at 16). To the contrary, the decision narrowly deals only with whether the particular phrase "satisfactory proof" or "satisfactory evidence" gives discretion to a plan administrator.

Indeed, the cases upon which Petitioner relies in arguing that other circuit courts of appeal have reached a different conclusion than the Sixth Circuit in *Perez* all involve a single insurer, the Standard Life Insurance Company or its successor, First Reliance Standard Life Insurance Company. *See Kearney v. Standard Life Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999); *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999); *Herzberger v. Standard Life Ins. Co.*, 205 F.3d 327 (7th Cir. 2000).[2]

This Court has denied certiorari to review even more fundamental issues regarding the standard of review for ERISA plans, such as the split among the circuits concerning whether the *de novo* standard of review applies to all issues regarding the denial of benefits or only to issues regarding plan interpretation. *Compare Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1183-84 (3d Cir. 1991); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210, 1213-14 (4th Cir. 1990); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379 n.2 (7th Cir. 1994) (all holding that *de novo* standard applies to all issues when ERISA claim denial is challenged, including fact questions) *with Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991) (holding that *de novo* standard

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2. Petitioner did not cite *Herzberger* in his Petition.

only applies to plan interpretation, while arbitrary and capricious standard applies to fact determinations).

Despite the split among the courts of appeal regarding that fundamental issue of the standard of review — which issue would affect every ERISA plan regardless of its terms — this Court denied certiorari to resolve the split. *Pierre v. Continental Gen. Life Ins. Co.*, 502 U.S. 973, 112 S. Ct. 453, 116 L. Ed. 2d 470 (1991).

The present Petition involves a much narrower and more confined issue having to do with the specific words of a plan, the resolution of which would have only modest impact. The issue is, by this Court's standards, not important enough to resolve through a writ of certiorari.

D. The Present Case Is Not The Proper "Vehicle" For Resolving Any Conflict.

The petition for certiorari should not be granted because the resolution of the standard of review issue would not entitle Petitioner to judgment. Aetna argued in the district court and court of appeals that collateral estoppel precluded Petitioner from asserting that no occupation exists for which he is qualified, since the Michigan workers' compensation magistrate determined in an administrative hearing that Petitioner was in fact employed and employable. The district court did not reach that issue, nor did the court of appeals sitting *en banc* (Appendix B at 16a-17a). Thus, even if this Court were to grant certiorari and reverse, it would at most result in remand to consider the independent state law defense of collateral estoppel. The presence of that defense makes the present case an improper vehicle for addressing the "conflict" that Petitioner urges.

II.

THE PETITION FOR CERTIORARI MUST BE DENIED BECAUSE IT IS UNTIMELY.

Petitioner seeks review of the United States Court of Appeals for the Sixth Circuit's *en banc* opinion of July 1, 1998, 150 F.3d 550 (6th Cir. 1998), which held that the particular plan language at issue vested discretion to the administrator, thereby invoking the arbitrary and capricious standard of review. Perez's Petition for Certiorari had to have been filed within ninety days of that opinion. It was not filed until May, 2000, or approximately two years after the opinion for which review is sought. The Petition for Certiorari must therefore be denied.

Rule 13.3 of the Rules of the Supreme Court of the United States provides that "[t]he time to file a petition for a writ of certiorari runs from the date of entry of the judgment or order sought to be reviewed . . . ." Rule 13.1 provides that "a petition for a writ of certiorari to review a judgment in any case, civil or criminal, entered by . . . United States court of appeals . . . is timely when it is filed with the Clerk of this Court within 90 days after entry of the judgment."[3]

28 U.S.C. § 2101(c) requires that a party file a petition for certiorari within 90 days of entry of the judgment or decree for which review is sought. The purpose of this and similar timing provisions for appeals is to "set a definite

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3. Rule 13.5 permits a party to file, and a Justice to grant, a 60 day extension. Perez made no such application and, of course, even if he had and one had been granted, his Petition would have been due not later than December, 1999.

point of time when litigation shall be at an end . . . ." *See Matton Steamboat Co. v. Murphy*, 319 U.S. 412, 63 S. Ct. 1126, 87 L. Ed. 1483 (1943). Although appeals are typically taken from final orders, 28 U.S.C. § 1254(1) eliminates the finality requirement for cases pending in the United States Court of Appeals. *See* Wright & Miller, *Federal Practice and Procedure*, § 4036 (1988) ("there is no requirement that there be a final decision; once a case has come to be in a court of appeals, the Supreme Court may grant certiorari to review interlocutory decisions or procedural rulings, and may grant review before the court of appeals has taken any action at all. Once review has been granted, moreover, the scope of the matters open for decision is approached entirely as a matter of wise judicial administration . . . ."); *Cf.* 28 U.S.C. §§ 1257 and 1291 (appeals from a state's highest court and from federal district courts must be from a final judgment).

Petitioner seeks review of a decision that was issued almost two years ago. The Petition is procedurally untimely and should be denied.

CONCLUSION

For all the reasons stated above, the Petition should be denied.

Respectfully submitted,

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